

**CHAPTER 22**

**HEALTH BENEFIT PLANS**

**Authority**

N.J.S.A. 17:1-8.1, 17:1-15e and P.L. 1999, c.339.

**Source and Effective Date**

R.2000 d.452, effective November 6, 2000.  
See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

**Chapter Expiration Date**

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 22, Health Benefit Plans, expires on May 5, 2006. See: 37 N.J.R. 3779(a).

**Chapter Historical Note**

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452, effective November 6, 2000. See: Source and Effective Date.

**CHAPTER TABLE OF CONTENTS**

**SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS**

- 11:22-1.1 Purpose and scope
- 11:22-1.2 Definitions
- 11:22-1.3 Acknowledgement of receipt of claims
- 11:22-1.4 Claim submission requirements
- 11:22-1.5 Prompt payment of claims
- 11:22-1.6 Denied and disputed claims
- 11:22-1.7 Prompt payment of capitation payments
- 11:22-1.8 Internal and external appeals
- 11:22-1.9 Reporting requirements
- 11:22-1.10 Remediation/penalty

**APPENDIX A NEW JERSEY CLAIMS PAYMENT EXHIBIT**

**APPENDIX A-1 INSTRUCTIONS**

**APPENDIX B QUARTERLY (ANNUAL) CLAIMS PROMPT PAYMENT REPORT**

**APPENDIX B-1 INSTRUCTIONS**

**SUBCHAPTER 2. HEALTH WELLNESS PROMOTION PLANS**

- 11:22-2.1 Scope
- 11:22-2.2 Definitions
- 11:22-2.3 Provision of a health wellness promotion program
- 11:22-2.4 Dollar amounts to be provided for services or benefits

**SUBCHAPTER 3. ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH CARE CLAIMS**

- 11:22-3.1 Purpose and scope
- 11:22-3.2 Definitions
- 11:22-3.3 Standard enrollment/change request forms and application/change request forms
- 11:22-3.4 Timetable and operational status reports
- 11:22-3.5 Extensions of time and exemptions from compliance
- 11:22-3.6 Health care providers; claims
- 11:22-3.7 Additional timetables
- 11:22-3.8 Use of clearinghouses in electronic transactions
- 11:22-3.9 Information protection practices

- 11:22-3.10 Fraud prevention and detection
- 11:22-3.11 Penalties

**EXHIBIT 1A**

**EXHIBIT 1B**

**SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS**

- 11:22-4.1 Purpose and scope
- 11:22-4.2 Definitions
- 11:22-4.3 License requirement
- 11:22-4.4 Application procedures
- 11:22-4.5 Application review procedures
- 11:22-4.6 Notice of change in documents
- 11:22-4.7 Examinations
- 11:22-4.8 Net worth, deposits and bond
- 11:22-4.9 Financial reports
- 11:22-4.10 Suspension or revocation
- 11:22-4.11 Plan for insolvency
- 11:22-4.12 Confidentiality
- 11:22-4.13 Penalties

**APPENDIX. EXHIBITS A THROUGH C**

**SUBCHAPTER 5. MINIMUM STANDARDS FOR NETWORK-BASED HEALTH BENEFIT PLANS**

- 11:22-5.1 Purpose and scope
- 11:22-5.2 Definitions
- 11:22-5.3 Network deductible
- 11:22-5.4 Network coinsurance
- 11:22-5.5 Aggregate dollar lifetime benefits maximums
- 11:22-5.6 Network and out-of-network coverage
- 11:22-5.7 Effect on previously-approved forms

**SUBCHAPTER 6. EXCLUSIONS AND PREAUTHORIZATION REQUIREMENTS**

- 11:22-6.1 Purpose and scope
- 11:22-6.2 Definitions
- 11:22-6.3 War exclusions
- 11:22-6.4 Requirements for preauthorization provisions
- 11:22-6.5 Effect on previously filed forms

**SUBCHAPTER 7. CARRIER/PROVIDER JOINT NEGOTIATION AGREEMENTS**

- 11:22-7.1 Purpose and scope
- 11:22-7.2 Definitions
- 11:22-7.3 Quarterly and annual reports

**APPENDIX A**

**APPENDIX B**

**SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS**

**Authority**

N.J.S.A 17:1-8.1, 17:1-15c, 17:29B-1 et seq., 17B:30-13.1, 26:2J-15b and 17B:30-23 et seq.

**Source and Effective Date**

R. 2001 d.13, effective January 2, 2001.  
See: 32 N.J.R. 1985(a), 33 N.J.R. 105(a).

**11:22-1.1 Purpose and scope**

(a) This chapter implements N.J.S.A. 17B:30-26 through 34, which sets standards for the payment of claims relating to health benefit plans and dental plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation, health maintenance organization, dental service corporation and dental plan organization that issues health benefit plans or dental plans in this State; any organized delivery system; and to any agent, employee or other representative of such entity that processes claims for such entity.

Amended by R.2003 d.446, effective November 17, 2003.

See: 35 N.J.R. 2394(a), 35 N.J.R. 5292(a).

In (b), inserted "any organized delivery system;" following "dental plans in this State;"

**11:22-1.2 Definitions**

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

"ADR" means alternate dispute resolution.

"Agent" means any entity, including a subsidiary of a carrier, or an organized delivery system as defined by N.J.S.A. 17:48H-1 with which a carrier has contracted to perform claims processing or claims payment services.

"Capitation payment" means a periodic payment to a health care provider for his services under the terms of a contract between the provider and a carrier, under which the provider agrees to perform the health care services set forth in the contract for a specified period of time for a specified fee, but shall not include any payments made to the provider on a fee-for-service basis.

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Commissioner" means the Commissioner of Banking and Insurance.

"Claim" means a request by a covered person, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the covered person, for payment relating to health care services or supplies or dental services or supplies covered under a health benefits plan or dental plan issued by a carrier.

"Clean claim" means:

1. The claim is for a service or supply covered by the health benefits plan or dental plan;

2. The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person;

3. The person to whom the service or supply was provided was covered by the carrier's health benefits or dental plan on the date of service;

4. The carrier does not reasonably believe that the claim has been submitted fraudulently; and

5. The claim does not require special treatment. For the purposes of this subchapter, special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

"Covered person" means a person on whose behalf a carrier offering the plan is obligated to pay benefits or provide services pursuant to the health benefits or dental plan.

"Covered service or supply" means a service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provides services or supplies.

"Dental plan" means a benefits plan which pays dental expense benefits or provides dental services and supplies and is delivered or issued for delivery in this State by or through any carrier in this State.

"Department" means the Department of Banking and Insurance.

"Health benefits plan" means a benefits plan which pays hospital and medical expense benefits or provides hospital and medical services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this chapter, health benefits plan shall not include the following plans, policies or contracts: accident only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.) or hospital confinement indemnity coverage.

"Health care provider" or "provider" means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist and other health care professional licensed pursuant to Title 45 of the Revised Statutes, and a hospital and other health care facilities licensed pursuant to Title 26 of the Revised Statutes.

EXHIBIT C

Organized Delivery System

Request for Withdrawal of Funds from Segregated Account

Name of Organized Delivery System: \_\_\_\_\_

Contact information of individual to whom correspondence concerning this request should be addressed:

Name \_\_\_\_\_

Title \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Amount of proposed withdrawal: \_\_\_\_\_

The proposed date of withdrawal: \_\_\_\_\_

Form of payment (cash or other assets): \_\_\_\_\_

The amounts and dates and forms of payment for all withdrawals (including withdrawals made pursuant to N.J.A.C.11:22-4.8(d) which did not exceed 10% of total net worth of the segregated account) made within the period of 12 months preceding the proposed date of withdrawal.

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

For the quarter immediately preceding:

Total Assets in Segregated Account at end of quarter: \_\_\_\_\_

Net Worth of Segregated Account at end of quarter: \_\_\_\_\_

Required Net Worth at end of quarter: \_\_\_\_\_

For the quarter following the withdrawal:

Projected assets in Segregated Account at end of quarter: \_\_\_\_\_

Projected Net Worth of Segregated Account at end of quarter: \_\_\_\_\_

Projected required Net Worth at end of quarter: \_\_\_\_\_

A brief statement as to the effect of the proposed withdrawal upon the organized delivery system's net worth and the reasonableness of net worth in relation to the organized delivery system's outstanding liabilities and the adequacy of net worth relative to the organized delivery system's financial needs.

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

Signature and certification:

SIGNATURE

Pursuant to the requirements of N.J.A.C. 11:22-4.8(d), \_\_\_\_\_ has caused this notice to be duly signed on its behalf in the City of \_\_\_\_\_ and State of \_\_\_\_\_ on the \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

(SEAL) \_\_\_\_\_  
Name of Applicant

BY \_\_\_\_\_  
(Name) (Title)

Attest:

\_\_\_\_\_  
(Signature of Officer)

\_\_\_\_\_  
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated \_\_\_\_\_, 20\_\_\_\_, for and on behalf of \_\_\_\_\_; that (s)he is the \_\_\_\_\_ of such company  
(Name of Company) (Title of Officer)

and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) \_\_\_\_\_

(Type or print name beneath) \_\_\_\_\_

**SUBCHAPTER 5. MINIMUM STANDARDS FOR NETWORK-BASED HEALTH BENEFIT PLANS**

**Authority**

N.J.S.A. 17:1-8.1, 17:1-15e, 17B:27A-54, 26:2J-42 and 26:2J-43.

**Source and Effective Date**

R.2003 d.419, effective November 3, 2003.  
See: 34 N.J.R. 3485(a), 35 N.J.R. 5116(a).

(b) This subchapter applies to all insurance companies, health service corporations, medical service corporations, hospital service corporations, and health maintenance organizations that deliver or issue for delivery health benefit plans in this State.

**11:22-5.1 Purpose and scope**

(a) This subchapter establishes minimum standards for health benefit plans that provide coverage only when network providers are used, and for health benefit plans that provide different levels of coverage depending on whether a network provider or an out-of-network provider is used.

**11:22-5.2 Definitions**

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

“Carrier” means an insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefit plans in this State.

“Health benefit plan” means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State.

1. “Health benefit plan” shall not include one or more, or any combination of, the following:

- i. Coverage for prescription drugs;
- ii. Coverage for accident only, disability income insurance;
- iii. Coverage issued as a supplement to liability insurance, including general liability insurance and automobile liability insurance;
- iv. Stop loss or excess risk insurance; workers’ compensation or similar insurance;
- v. Automobile personal injury protection medical expense benefits or medical payment insurance;
- vi. Credit only insurance;
- vii. Coverage for on-site medical clinics; and
- viii. Other similar insurance coverage as specified in Federal regulations under which benefits for medical care are secondary or incidental to other insurance benefits.

2. “Health benefit plan” 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:

- i. Limited scope dental, drug or vision benefits;
- ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
- iii. Such other similar, limited benefits as are specified in Federal regulations.

3. “Health benefit plan” shall not include hospital confinement indemnity coverage if:

- i. The benefits are provided under a separate policy, certificate or contract of insurance;
- ii. There is no coordination between the provision of the benefits and any exclusion of benefits under any

group health benefit plan maintained by the same plan sponsor; and

iii. 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.

4. “Health benefit plan” shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

i. Medicare supplemental health insurance as defined at Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1));

ii. Coverage that is supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and

iii. Similar supplemental coverage provided to coverage under a group health plan.

“Network coinsurance” means the percentage of the contractual fee of the network provider for covered services and supplies specified in the contract between the provider and the carrier that must be paid by the covered person, subject to deductible and out-of-pocket limit. Network coinsurance cannot be applied to services or supplies provided by capitated providers.

“Network copayment” means the specified dollar amount a covered person must pay for covered services and supplies rendered by network providers.

“Network deductible” means the fixed dollar amount that a covered person or family must pay to network providers before the health benefit plan provides the covered person with coverage for services or supplies rendered by network providers. A network deductible shall not be applied to services or supplies provided by capitated providers.

“Network out-of-pocket limit” means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar year. All amounts paid as copayment, coinsurance and deductible shall count toward the out-of-pocket maximum, and shall not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason. Once the network out-of-pocket limit has been reached, the covered person has no further obligation to pay any amounts as copayment, coinsurance or deductible for services and supplies provided by network providers for the remainder of the calendar year.

“Point of service contract” or “POS contract” means a health benefit plan issued by a health maintenance organization or health service corporation that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by

out-of-network providers. The term also includes dual contracts issued pursuant to N.J.A.C. 8:38-14.7, whereby a health maintenance organization contract provides network benefits and an insurance company contract provides out-of-network benefits.

“Preventive care” means services or supplies that are not provided in connection with the treatment of injury or illness. Preventive care includes, but is not limited to: routine physical examinations including related laboratory tests and x-rays, immunizations and vaccines, screening tests, well baby care, well child care and well adult care.

“Selective contracting arrangement contract” or “SCA policy” means a health benefit plan issued by an insurance company that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers.

#### 11:22-5.3 Network deductible

(a) An individual network deductible is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy issued by an insurance company, provided that:

1. The contract or policy contains an individual network out-of-pocket limit that is no greater than \$5,000, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit;
2. The individual network deductible is no greater than \$2,500;
3. The individual network deductible is not applied to preventive care; and
4. The contract contains a family network deductible no greater than two times the individual network deductible.

#### 11:22-5.4 Network coinsurance

(a) Network coinsurance is permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, and in a SCA policy issued by an insurance company, provided that:

1. The contract contains an individual network out-of-pocket limit that is no greater than \$5,000, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit;
  - i. If a carrier offers a contract with an individual network out-of-pocket limit in excess of \$3,000, it shall also offer a contract with an individual network out-of-pocket limit of \$2,500 or less.

2. The network coinsurance level, and the out-of-network coinsurance level (if any), is 50 percent or less;
3. The network coinsurance obligation of the covered person is computed by applying the coinsurance percentage to the contractual fee schedule of the provider, not to the billed charges of the provider; and
4. Network coinsurance cannot be applied to preventive care.

#### 11:22-5.5 Aggregate dollar lifetime benefits maximums

(a) Aggregate dollar lifetime benefits maximums for network services and supplies are not permitted in a contract issued by a health maintenance organization that provides out-of-network benefits only for emergency and urgent care, in a POS contract issued by a health maintenance organization or health service corporation, or in a SCA policy issued by an insurance company.

(b) Aggregate dollar lifetime benefits maximums for out-of-network services and supplies are permitted in a POS contract issued by a health maintenance organization or a health service corporation, or in a SCA policy issued by an insurance company, only if such maximums are in the amount of \$5 million or greater and are imposed on a per-plan per-carrier basis.

#### 11:22-5.6 Network and out-of-network coverage

(a) POS contracts issued by health maintenance organizations and health service corporations, and SCA policies issued by insurance companies, shall provide coverage for covered services and supplies regardless of whether rendered by a network or an out-of-network provider, with the following exceptions:

1. The following services and supplies may be covered only when provided by a network provider, and are not required to be covered when provided by an out-of-network provider:
  - i. Health club membership;
  - ii. Prescription drugs, other than insulin and oral agents for controlling blood sugar as mandated by N.J.S.A. 17:48-6n, 17:48A-7l, 17:48E-35.11, 17B:26-2.11, 17B:27-46.1m and 26:2J-4.11, and medications to treat infertility as mandated by N.J.S.A. 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x and 26:2J-4.23;
  - iii. Routine dental examinations;
  - iv. Routine eye care and appliances;
  - v. Routine foot care;
  - vi. Routine hearing care and appliances;
  - vii. Smoking cessation programs; and
  - viii. Travel companion benefits.

(b) All contracts issued by health maintenance organizations and health service corporations, and all SCA policies issued by insurance companies, shall provide the following:

1. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the covered person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible and/or coinsurance applicable to network services; and

2. That a covered person's liability for services rendered during a hospitalization in a network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is an out-of-network provider, shall be limited to the copayment, deductible and/or coinsurance applicable to network services.

#### 11:22-5.7 Effect on previously-approved forms

Any form that was filed with and approved by the Commissioner prior to November 3, 2003, but does not meet the requirements of this subchapter, shall be deemed withdrawn immediately and may not be made available for sale or use.

## SUBCHAPTER 6. EXCLUSIONS AND PREAUTHORIZATION REQUIREMENTS

### Authority

N.J.S.A. 17:1-8.1 and 15e, 17B:27-49g and 26:2J-43h.

### Source and Effective Date

R.2004 d.80, effective February 17, 2004.  
See: 35 N.J.R. 2396(a), 36 N.J.R. 958(a).

#### 11:22-6.1 Purpose and scope

(a) This chapter specifies standards for war and other exclusions and preauthorization requirements in health benefit plans.

(b) This chapter applies to any insurance company, health service corporation, medical service corporation, hospital service corporation and health maintenance organization that issues health benefit plans in New Jersey.

#### 11:22-6.2 Definitions

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

“Act of war” means any act peculiar to military, naval or air operations in time of war.

“Carrier” means an insurance company, health service corporation, hospital service corporation, medical service

corporation, or health maintenance organization authorized to issue health benefit plans in this State.

“Covered person” means a person on whose behalf a carrier is obligated to pay benefits or provide services pursuant to the health benefits plan.

“Health benefits plan” means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier. For purposes of this subchapter, “health benefits plan” shall 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; 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 benefit 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 benefit plans 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 (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

“Home area” means the 50 states of the United States of America, the District of Columbia and Canada.

“Preauthorization” means the process by which carriers determine the medical necessity and/or medical appropriateness of otherwise covered treatments and procedures prior to the rendering of such treatments and procedures including, but not limited to, preadmission review, pretreatment review, utilization and case management.

"War" includes, but is not limited to, declared war, and armed aggression by one or more countries resisted on orders of any other country, combination of countries or international organization.

### 11:22-6.3 War exclusions

(a) The Department shall permit war risk exclusions in health benefit plans only if they consist of military exclusions, noncombatant exclusions and/or civilian exclusions. Military, noncombatant and civilian exclusions shall be no more restrictive than the following:

1. Military exclusions may exclude treatment of illness or injury suffered:

i. As a result of war or an act of war, if the illness or injury occurs while the covered person is serving in the military, naval or air forces of any country, combination of countries or international organization; and

ii. As a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the illness or injury occurs while the covered person is serving in such forces and is outside the home area.

2. Non-combatant civilian exclusions may exclude treatment of injury or illness suffered:

i. As a result of war or an act of war while the covered person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and

ii. As a result of the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or injury occurs while the covered person is serving in such unit and is outside the home area.

3. Civilian exclusions may exclude treatment of illness or injury suffered as a result of war or an act of war while the covered person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the illness or injury occurs outside the home area.

### 11:22-6.4 Requirements for preauthorization provisions

Preauthorization provisions may be included in health benefit plans only upon compliance with the requirements of N.J.A.C. 11:4-42.8, except for N.J.A.C. 11:4-42.8(a)5.

### 11:22-6.5 Effect on previously filed forms

Forms filed before February 17, 2004 with noncomplying war exclusions and/or preauthorization provisions shall be administered in accordance with the standards of N.J.A.C. 11:22-6.3 and 6.4 and shall be deemed withdrawn as of January 1, 2005.

## SUBCHAPTER 7. CARRIER/PROVIDER JOINT NEGOTIATION AGREEMENTS

### Authority

N.J.S.A. 17:1-8.1 and 17:1-15e, and 52:17B-196 et seq.

### Source and Effective Date

R.2004 d.295, effective August 2, 2004.  
See: 35 N.J.R. 5036(a), 36 N.J.R. 3553(a).

### 11:22-7.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 52:17B-196 et seq., which provides for joint negotiations regarding non fee-related matters, fees and fee-related matters by physicians and dentists with carriers. This subchapter establishes standards and procedures for carriers to report to the Department certain information concerning the number of a carrier's covered lives and the impact of provider negotiations conducted pursuant to N.J.S.A. 52:17B-196 et seq.

(b) This subchapter shall apply to all insurance companies, health service corporations, hospital service corporations, medical service corporations and health maintenance organizations authorized to issue health benefits plans in this State. This subchapter shall also apply to all dental service corporations and dental plan organizations authorized to issue dental plans in this State.

### 11:22-7.2 Definitions

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

"Carrier" means an insurance company, health service corporation, hospital service corporation, medical service corporation or health maintenance organization authorized to issue health benefits plans in this State, and a dental service corporation or dental plan organization authorized to issue dental plans in this State.

"Covered lives" means covered persons for purposes of required reporting of the number of such persons.

"Covered person" means a person on whose behalf a carrier, which offers a health benefits or dental plan, is obligated to pay benefits or provide services pursuant to that plan.

"Covered service" means a health care or dental service or supply provided to a covered person under a health benefits or dental plan for which the carrier is obligated to pay benefits or provide services subject to contractual provisions such as deductible, coinsurance and copayment.

"Department" means the New Jersey Department of Banking and Insurance.