

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), 38 N.J.R. 1005(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 Re-adoption 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 Exhibit R, was 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. Appendix Exhibits A, C, E and U were repealed by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006). Exhibits A, C and E were adopted as new rules. See: Source and Effective Date. See, also, section annotations.

Exhibit H of the Appendix was adopted as new rules by R.2009 d.45, effective December 29, 2008. See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

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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## SUBCHAPTER 1. GENERAL PROVISIONS

**11:20-1.1 Purpose and scope**

(a) This chapter implements provisions of P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 et seq.), the Individual Health Insurance Reform Act, as amended. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-2 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Individual Health Coverage Program pursuant to N.J.S.A. 17B:27A-2 et seq.

(b) Provisions of the New Jersey Individual Health Insurance Reform Act and of this chapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term member is defined in this subchapter, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Individual Health Insurance Reform Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after August 1, 1993,

except as the specific provisions of the statute and of this chapter state otherwise.

Petition for Rulemaking: Exhibit F.  
See: 26 N.J.R. 862(a), 26 N.J.R. 1401(a), 26 N.J.R. 2488(a).  
Petition for Rulemaking: Exhibit F.  
See: 26 N.J.R. 4228(b), 26 N.J.R. 4452(d), 27 N.J.R. 1321(a).  
Petition for Rulemaking: Exhibit F.  
See: 26 N.J.R. 5119(a), 27 N.J.R. 946(d).  
Petition for Rulemaking: Exhibits A through F.  
See: 26 N.J.R. 5120(b), 27 N.J.R. 946(b).  
Petition for Rulemaking: Exhibit D.  
See: 28 N.J.R. 1315(a), 28 N.J.R. 2413(b).  
Amended by R.1998 d.443, effective August 7, 1998.  
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "as amended" at the end of the first sentence; in (b), inserted "as the term member is defined in this subchapter" following "Coverage Program"; and in (c), substituted "August 1, 1993" for "November 30, 1992".

**11:20-1.2 Definitions**

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means the Individual Health Insurance Reform Act, P.L. 1992, c.161 (N.J.S.A. 17B:27A-2 through 16.5).

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another.

"Basic and essential health care services plan" means the health benefits plan pursuant to P.L. 2001, c.368, N.J.S.A. 17B:27A-4.4 through 4.7.

"Board" means the Board of Directors of the New Jersey Individual Health Coverage Program established by the Act.

"Carrier" means any entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits or health services. For purposes of this chapter, carriers that are affiliated carriers shall be treated as one carrier.

"Church plan" has the same meaning given that term under Title I, section 3 of Pub.L. 93-406, the "Employee Retirement Income Security Act of 1974" (29 U.S.C. § 1002(33)).

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

"Community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that con-

tract, without regard to age, sex, health status, occupation and geographical location.

“Conversion health benefits plan” means a group conversion contract or policy issued on or after August 1, 1993 that is not subsidized by either:

1. A single charge or ongoing increase in premium rates chargeable to the group policy or contract, identifiable as an excess morbidity charge in the group rating formula to cover group conversion excess morbidity costs; or
2. A reduction in dividends or returns paid to a group policy or contract holder, identifiable as a charge to or reduction in the group dividend or return formula to cover group conversion excess morbidity costs.

“Deferral” means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

“Department” means the New Jersey Department of Banking and Insurance.

“Dependent” means:

1. The applicant’s spouse;
2. The applicant’s same-gender domestic partner as that term is defined in P.L. 2003, c. 246;
3. The applicant’s civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships recognized in other jurisdictions if such relationships provide substantially all of the rights and benefits of marriage;
4. A child or step child of the applicant;
5. A child of the applicant’s domestic partner subject to applicable terms of the individual health benefits plan; or
6. A child of the applicant’s civil union partner subject to applicable terms of the individual health benefits plan.

“Director” means a Director of the Individual Health Coverage Program Board who, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, §5:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;
2. Has been appointed by the Governor and confirmed by the Senate; or
3. Sits ex officio on the Board of Directors.

“Eligible person” means a person is a resident who is not eligible to be covered under a group health benefits plan, group health plan, governmental plan, church plan, or Part A or Part B of Title XVIII of the Federal Social Security Act (42 U.S.C. §§1395 et seq.), “Medicare.” An eligible person

shall include a person who is a resident who is eligible for continuation of group coverage under COBRA or a state continuation law, so long as the person elects to be covered under the individual health benefits plan in lieu of continuation coverage.

“Enrollment date” means, with respect to a Federally defined eligible individual, the date the person submits a substantially complete application for coverage. With respect to all other persons, enrollment date means the effective date of coverage under the individual health benefit plan.

“Family unit” means:

1. A legally married man and woman;
2. A person and his or her same-gender civil union partner;
3. A person and his or her same gender domestic partner;
4. A legally married man and woman and their dependent children;
5. A person and his or her same-gender civil union partner and their dependent children, as the term dependent is defined in the individual health benefits plan;
6. A person and his or her same gender domestic partner and their dependent child(ren), as the term dependent is defined in the individual health benefits plan;
7. An adult and his or her dependent child(ren), as the term dependent is defined in the individual health benefits plan, who are members of the same household; and
8. Dependent children only who are members of the same household as the term dependent is defined in the individual health benefits plan.

“Federally defined eligible individual” means an eligible person:

1. For whom, as of the date on which the individual seeks coverage under P.L. 1992, c. 161 (N.J.S.A. 17B:27A-2 et seq.), the aggregate of the periods of creditable coverage is 18 or more months during which time the eligible person has not had any significant break in coverage (significant break in coverage means a break in coverage of 63 days or more during which time the eligible person has no creditable coverage);
2. Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan, or health insurance coverage offered in connection with any such plan;
3. Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§1395 et seq.), or a State plan under Title XIX of the Social Security Act (42 U.S.C. §§1396 et seq.) or any successor program, and who does

Administrative correction.

See: 30 N.J.R. 1318(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.

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).

In (a), substituted "Individual" for "Basic" in 2, and added 7; in (b), inserted a reference to Plan A/50, deleted a reference to Plan E, inserted a reference to Exhibit U and substituted a reference to Exhibit D for a reference to Exhibit E in the introductory paragraph, deleted a reference to Plans B and E in the introductory paragraph of 1, and inserted a reference to Plans A/50 and B in the introductory paragraph of 2; in (c), substituted a reference to Plans A/50, B, C, and D for a reference to Plans B through E in the first sentence, and added 3; and in (d), inserted a reference to Plan A/50 in the first sentence, substituted a reference to Exhibit D for a reference to Exhibit E in 2, inserted a reference to \$30.00 copayment levels in 3, and deleted ", and Plan E shall have an out-network level of 99 percent" at the end of 4.

Amended by R.1999 d.131, effective March 25, 1999.

See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).

In (b)3, rewrote i and ii.

Amended by R.2002 d.95, effective March 18, 2002 (operative August 1, 2002).

See: 33 N.J.R. 4057(a), 34 N.J.R. 1277(a).

Added (b)4.

Amended by R.2002 d.331, effective October 7, 2002.

See: 34 N.J.R. 1786(a), 34 N.J.R. 3527(a).

In (b)4, substituted "may" for "shall".

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Amended by R.2005 d.160, effective April 22, 2005.

See: 37 N.J.R. 1481(a), 37 N.J.R. 1736(a).

In (b), added iii through vi in 3.

Repeal and New Rule by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Rewrote (b); in the introductory paragraph of (c), inserted "offering at least three of" and "at least two of", and substituted "(a)" for "(b)" and "\$30.00" for "\$15.00"; in (c)1i and (c)1ii(1), substituted "\$300.00" for "\$150.00" and "\$30.00" for "\$15.00"; in (c)2i(4) and (d)5, substituted "no greater than \$7,500" for "5,000"; in (d)2, substituted "no greater than" for "\$1,000 or"; in (d)5, substituted "no greater than two times the per covered person network maximum out of pocket" for "\$10,000"; and added (e).

### 11:20-3.2 Certification of Compliance

(a) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification of Compliance set forth in the Appendix to this subchapter as Exhibit E, incorporated here by reference. Each affiliated carrier must file a separate Certification of Compliance. A Certification of Compliance must be filed upon entry into the individual market, and annually on or before March 1.

(b) Carriers that submit an Exhibit E Certification of Compliance may issue and make effective individual health benefits plans upon filing such Certification with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board. The Board may disapprove an Exhibit E Certification of Compliance if the Certification is inaccurate or incomplete.

(c) Any carrier whose Certification of Compliance is denied may file an appeal of the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

Repeal and New Rule, 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).

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.

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).

In (a), inserted a reference to Exhibit U; and in (b), deleted a reference to Exhibit E, and substituted a reference to Exhibit D for a reference to Exhibit E.

Repeal and New Rule by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

Section was "Policy forms".

### 11:20-3.3 Compliance and variability rider

(a) Members may incorporate regulatory changes required to be made to the standard policy forms, standard HMO contract, and standard riders through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, incorporated herein by reference, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms that Compliance and Variability Riders may be used. Carriers may only use the Compliance and Variability Rider to incorporate Board designated text for the period of time specified by the Board in the rule adoption of the regulatory changes to the standard policy forms.

(b) Members may make any changes to the standard policy forms, standard HMO contract, or standard riders promulgated by the Board consistent with the permitted as variable text set forth in Exhibits A and B of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit C, through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix.

(c) Members may incorporate text for benefits required to be offered to the Policyholder through the use of the Compliance and Variability Rider as set forth as Exhibit D of the Appendix, if the Board has indicated in the rule adoption of the regulatory changes to the standard policy forms to address the mandated offer that carriers may issue the optional coverage by rider in lieu of including the coverage in the standard policy forms. For example, coverage for autologous bone marrow transplant, as required to be offered pursuant to P.L. 1995, c. 100, may be included using the Compliance and Variability Rider.

(d) Members may not use the Compliance and Variability rider to accomplish benefit modifications as outlined in N.J.A.C. 11:20-3.6.

New Rule, R.1996 d.542, effective December 2, 1996.

See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

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

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

In (b), inserted "as described in the Explanation of Brackets, Exhibit T," following "Chapter".

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).

In (b), substituted a reference to Exhibit U for a reference to Exhibit F.

Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

In (a) and (b), substituted "Members" for "Notwithstanding the requirements of N.J.A.C. 11:20-3.2, members", rewrote references to all Exhibits and added (c).

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Added (d).

### 11:20-3.4 Plan update rider

(a) Members electing to force convert existing standard plans pursuant to N.J.A.C. 11:20-24.7 and issuing new standard plans, as set forth in Exhibit A or B of the Appendix to this chapter, shall issue the Plan Update Rider, as set forth in Appendix Exhibit G, incorporated herein by reference. Such rider shall be issued to policyholders who:

1. Have coverage under a plan utilizing deductible and coinsurance provisions on the day before the plan anniversary date the forced conversion is effective; and
2. Elect to enroll in the standard health benefits plan which is offered as a conversion plan by the same carrier.

(b) The Plan Update Rider shall expire at midnight on December 31 of the calendar year in which it was issued.

New Rule, by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).

See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).

Former N.J.A.C. 11:20-3.4, recodified as N.J.A.C. 11:20-3.5.

Amended by R.2009 d.45, effective December 29, 2008.

See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

Rewrote (a).

### 11:20-3.5 Basic and essential health care services plan

The basic and essential health care services plan established by the Legislature contains the benefits, limitations and exclusions set forth in N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22. A specimen policy form is set forth in Appendix Exhibit F.

New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

Substituted "N.J.S.A. 17B:27A-4.5. Rules regarding this plan are set forth at N.J.A.C. 11:20-22" for "N.J.S.A. 11:20-22" and substituted "Exhibit F" for "Exhibit V".

Recodified from N.J.A.C. 11:20-3.4 by R.2006 d.119, effective February 24, 2006 (operative July 1, 2006).

See: 38 N.J.R. 1306(a), 38 N.J.R. 1459(a).

### 11:20-3.6 Optional benefit riders to standard plans

(a) Members may offer riders that revise the coverage offered by Plans A/50, B, C, D, and HMO, subject to the provisions set forth in (a)1 through 8 below.

1. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A/50, B, C, D, or HMO, the member shall file the rider or amendment thereof with the Board for informational purposes.

2. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO means:

i. The types and extent of services and supplies described in the "Covered Charges," "Covered Charges with Special Limitations" and "Exclusions" sections of Plans A/50, B, C, and D or the "Covered Services and Supplies" and "Non-Covered Services and Supplies" sections of the HMO plan;

ii. Deductibles, coinsurance, copayments, maximum out of pocket, network maximum out of pocket and non-network maximum out of pocket of Plans A/50, B, C, D and HMO as applicable (including, but not limited to, deductible provisions such as deductible waiver, year-end deductible carry-over, and first dollar coverage), and their applicability in situations involving common accident.

3. For purposes of optional benefit riders filed pursuant to (a)1 above, "coverage" offered by Plans A/50, B, C, D, or HMO does not include:

i. Provider networks;

ii. Coverage which is specifically excluded from the definition of "health benefits plan" in N.J.A.C. 11:20-1.2, except for dental coverage where the additional dental coverage is subject to the standard plan's deductible and coinsurance or copayment schedule, as applicable; or

iii. Benefits which are other than those provided under a "health benefits plan" as defined at N.J.A.C. 11:20-1.2.

4. In addition to (a)1, 2 and 3 above, any benefit rider or amendments thereof shall be subject to the provisions of N.J.S.A. 17B:27A-4 and 17B:27A-6.

5. The inclusion of an optional benefit rider with Plan A/50, B, C, D or HMO creates Plan A/50, B, C, D or HMO as amended by the rider and the Plan continues to be Plan A/50, B, C, D or HMO. The inclusion of an optional benefit rider does not create another standard plan.

6. An individual seeking to purchase Plan A/50, B, C, D or HMO must be given the opportunity to purchase Plan A/50, B, C, D or HMO without a rider or with any rider that is available to amend the plan being purchased.

7. A member making an informational filing to the Board pursuant to (a)1 above shall:

i. Submit one copy of the filing and any related materials to the Board at the address specified at N.J.A.C. 11:20-2.1;

ii. Submit one copy of the rider or riders which amend the standard plans, which rider or riders shall include cross-references to the standard plan provisions or sections and/or pages which are being modified;

iii. Specify whether the rider or amendment thereof is to be used in connection with standard health benefit Plans A/50, B, C, D or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

iv. The standard plan language shall not be altered, and the benefit modifications shall appear only on the rider or riders;

v. Submit the standard plan page or pages which are affected by the rider or riders marked to identify which provisions are affected by the rider or riders; and

vi. Submit a certification signed by a duly authorized officer of the member that states clearly:

(1) That the rider or amendment thereof increases a benefit or benefits and does not include a decrease of any benefits or decrease in the actuarial value of standard health benefits Plan A/50, B, C, D, or HMO;

(2) That the filing is complete and in accordance with all the requirements of this subsection and applicable New Jersey statutes and regulations;

(3) That the member will offer the rider or amendment thereof to any individual seeking to purchase the health benefits plan it modifies;

(4) That a rate filing for the rider has been made with the Commissioner pursuant to N.J.A.C. 11:20-6; and

(5) If amending a plan, or a plan and a rider or riders, sold through or in conjunction with a selective contracting arrangement, that the plan as ridered continues to comply with the requirements set forth in N.J.A.C. 11:4-37.3(b)6 and 11:24-14.4(c), as applicable.

8. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in compliance with the requirements of this subchapter within 45 days of the Board's receipt of the member's submission of a rider. If the Board does not notify a member of its determination with respect to an informational filing within 45 days of the Board's receipt of the submission, the informational filing shall be deemed complete and in compliance.

i. If an informational filing is incomplete or not in compliance, the notification shall provide the reasons the filing is incomplete or not in compliance and what additional information needs to be submitted by the member. The member shall provide the Board with the necessary information such that the filing will be complete and in compliance. Upon receipt of notice from the Board that a filing is incomplete or not in compliance, the member shall not sell the rider until the member has received written notice from the Board that the informational filing is complete and in compliance.

ii. If the Board takes no action within 45 days of receipt by the Board of a member's submission of information requested by the Board, the filing shall be deemed to be complete and in compliance.

New Rule. R.2009 d.45, effective December 29, 2008.  
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

### 11:20-3.7 Plan or plan option withdrawal by IHC Board

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within 90 days after the rules take effect.

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall nonrenew that individual plan, plan option, or deductible/copayment option pursuant to the procedures set forth in (c) and (d) below.

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

6. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal.

(d) Not more than 60 days after the Board has promulgated regulations withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal to the producer of record, if any, for each policy or contract. Nonrenewal notices for producers shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of N.J.A.C. 11:20-3.7;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal; and

6. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

New Rule, R.2009 d.45, effective December 29, 2008.  
See: 40 N.J.R. 6904(a), 41 N.J.R. 799(b).

SUBCHAPTERS 4 THROUGH 5. (RESERVED)

SUBCHAPTER 6. INDIVIDUAL HEALTH BENEFITS  
CARRIERS INFORMATIONAL RATE FILING  
REQUIREMENTS

**11:20-6.1 Purpose and scope**

The purpose of this subchapter is to establish informational rate filing requirements and procedures for members issuing or renewing individual health benefits plans pursuant to

section 3 of the Act (N.J.S.A. 17B:27A-4) as well as the basic and essential health care services plan pursuant to P.L. 2001, c. 368.

Amended by R.2003 d.91, effective January 28, 2003.  
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Inserted "as well as the basic and essential health care services plan pursuant to P.L. 2001, c.368" following the N.J.S.A. references.  
Amended by R.2006 d.15, effective January 3, 2006.

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

Substituted "section" for "sections 2b(1) and" and updated the N.J.S.A. reference.

**11:20-6.2 Definitions**

Words and terms, when used in this subchapter, shall have the meanings defined by the Act, N.J.A.C. 11:20-1.2, or as further defined below, unless the context clearly indicates otherwise.

"Informational filing" means a submission by a carrier of rate manuals which specify the plans offered, premium rates, all factors to be used in the calculation of premium rates, and a detailed actuarial memorandum supporting the calculation of the rates, a certification by a member of the American Academy of Actuaries, all supporting data for the premium rates and such other information as the Board from time to time requests or requires.

**11:20-6.3 Informational rate filing requirements**

(a) All members issuing standard health benefits plans on a new contract or policy form and the basic and essential health care services plan shall make, prior to issuing any standard health benefits plan, an informational rate filing with the Board, which shall include the following supporting data:

1. Rate manuals specifying the standard health benefits plans and the basic and essential health care services plan, with riders, if any, offered. The manuals shall not include references to, or premiums containing assumptions based upon, an individual's claims experience, underwriting, substandard ratings, occupational limitations or any other factors prohibited by the Act, except that the rates for the basic and essential health care services plan and any riders thereto may consider age, gender and geography, as permitted by P.L. 2001, c.368 and N.J.A.C. 11:20-6.5;

2. Monthly premium rates and any factors used in the calculation of the premium rates and the effective dates for the rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date. Unless a carrier amends the rate filing to specify an alternative effective date, carriers shall use the rates shown in the rate filing, as of the stated effective date. Rates may be developed on different rate tiers for: single; two adults; adult/child(ren); and family; and with respect to the basic and essential health care services plan, and any riders thereto, a description of the rating methodology or plan and the numerical value of the classification factors utilized in determining a policyholder's rates that addresses

the use of the factors of age, gender and geography as discussed in (a)2i, ii and iii below, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals. The filing for the basic and essential health care services plan shall include:

i. The numerical value of the classification factors utilized in the calculation of an individual's premium rate or rates, limited to: age, gender, geographic location, effective date, and rating tier of each covered adult in accordance with the factors set forth in N.J.A.C. 11:20-6.5;

ii. A written description (non-formulaic) of the rating methodology in plain language so that a knowledgeable member of the public may understand how to translate the basic rates into the rates charged for an individual policy; and

iii. A detailed example calculation, in the proposal format used by the carrier, for the basic and essential health care services plan, including any rider option(s), showing all the steps to develop premiums for a policy and demonstrating the adjustment, if any, to achieve the required 350 percent maximum ratio between premiums for the highest rated individual policyholder and the lowest rated individual policyholder in the State;

3. A detailed actuarial memorandum, which shall include the following:

i. The monthly rates being submitted for each period addressed in the rate filing along with factors or actual rates for quarterly or semi-annual modes, if such modes are available;

ii. Identification of the plans affected, using the alphabet name if indemnity or PPO, and the copay and coinsurance, if applicable, if HMO;

iii. Application of the rates to new business and renewal business;

iv. The duration of the rate guarantee period, and if none, so state;

v. A sample of the notice that will be sent to policyholders to advise them of a rate change, except that such sample notice must only be included with the first rate filing submitted on or after January 3, 2006, and thereafter, whenever there is a change to the content of the notice previously submitted.

vi. All information used in the development of the rates;

vii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including:

(1) Historical experience, whether or not the experience is credible. At a minimum the historical experience should specify premium, claims and loss ratio data from the period used in the development of the anticipated loss ratio, where the period should be at least 12 months;

(2) Trend assumptions, if a carrier uses multiple assumptions, the average may be shown;

(3) Plan relativity assumptions, if a carrier uses plan relativity assumptions in calculating anticipated loss experience; and

(4) Any other factors used in developing the anticipated loss experience; and

viii. Specific identification of the administrative expense, premium tax and commission payment assumptions, and other margins; and

ix. Specification of the percentage change(s) in rates as compared to the prior rating period and the average change for all plans.

4. A certification signed by a member of the American Academy of Actuaries, which shall include the following:

i. A statement that the informational filing is complete;

ii. A statement that the carrier's loss ratio is expected to be at least 75 percent;

iii. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, a statement that the rating methodology will not produce rates (for each rate tier) for the highest rated policyholder which are greater than 350 percent of the rates (for each rate tier) for the lowest rated policyholder for each basic and essential health care services plan and rider option; and

iv. For rates to be charged for the basic and essential health care services plan, and any optional benefit riders thereto, the anticipated loss ratio for the plan; and

5. Such other information or data as may be required or requested by the Board to analyze the adequacy of the rate filing submitted.

(b) Any member which seeks to change its rates for its standard health benefits plans or its basic and essential health care services plan shall, prior to the effective date of the revised rates, submit to the Board an informational rate filing, which shall include all the supporting data set forth in (a) above.

(c) Unless a carrier submits an amended rate filing to specify an alternate effective date, carriers shall use the rates shown in the rate filing as of the stated effective date.

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.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote (a); in (b), inserted "its basic and essential health care services plan" preceding "or its community rated".

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

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

In (a)2, substituted "Monthly" for "Premium" at the beginning of the paragraph, substituted "two adults" for "husband/wife", and inserted "and" preceding "family;"; rewrote (a)3 and (b); added (c).

#### 11:20-6.4 Informational rate filing procedures

(a) A member shall file one copy of the informational rate filing with the Executive Director at the address set forth in N.J.A.C. 11:20-2.1(h) pursuant to N.J.A.C. 11:20-6.3(a) or (b).

(b) If the Board determines that an informational filing filed pursuant to N.J.A.C. 11:20-6.3(a) or (b) is incomplete, the Board shall provide written notice to the member specifying those portions of the filing which are deficient and the information required to be submitted or resubmitted by the member.

(c) Within 15 days of receipt of written notice in (b) above, the member shall provide the Board with the information required to complete the filing.

(d) Upon notice that the filing is incomplete, the member shall not use the filed rates in either the quoting or billing process until the Board has determined that the informational

filing is complete, and written notice of that determination has been provided to the member.

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).

Rewrote (a); and deleted former (e).

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

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

Rewrote (a); in (c), substituted "Within" for "Upon"; in (d), inserted "in either the quoting or billing process" following "the filed rates" and substituted "determination" for "fact".

### 11:20-6.5 Permissible rate classification factors

(a) A carrier shall not differentiate premium rates charged to different individuals for the basic and essential health care services plan and rider(s), if any, except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a policyholder on the basis of the address of the policyholder's place of residence. The six territories are the following:

- i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;
- ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;
- iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;
- iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;
- v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden and Mercer counties; and
- vi. Territory F consists of zip codes 080, 082-084 and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates on the basis of family structure according to only the following four rating tiers:

1. Single;
2. Two adults;
3. Adult and child(ren); and
4. Family.

New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

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

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

Rewrote (a); in (b)2, substituted "Two adults" for "Husband and wife".

## SUBCHAPTER 7. LOSS RATIO AND REFUND REPORTING REQUIREMENTS

### 11:20-7.1 Purpose

The purpose of this subchapter is to implement the loss ratio and refund reporting requirements of the Act.

### 11:20-7.2 Definitions

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

"Claims paid" means a dollar amount determined in accordance with statutory annual statement reporting and consistent with N.J.A.C. 11:20-8.5(c), adjusted as required by this subchapter.

"Preceding calendar year" means the calendar year immediately preceding the reporting year.

"Reporting year" means the year in which the loss ratio report is required to be filed with the Board.

New Rule, R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

### 11:20-7.3 Filing of Loss Ratio Report

(a) Each member that had a standard health benefits plan or a basic and essential health care services plan in force during the preceding calendar year shall file with the Board an annual Loss Ratio Report on the form appearing as Exhibit J in the Appendix to this chapter incorporated herein by reference. Affiliated carriers shall file a separate report for each carrier that had standard health benefits plans or the basic and essential health care services plan in force during the preceding calendar year plus a combined report reflecting the combined data for all affiliated carriers.

(b) The Report shall be filed on the basis of the combined total of the standard health benefits plans and the basic and essential health care services plan written by the member.

(c) The Report shall be completed and filed with the Board on or before August 15 of the reporting year for the preceding calendar year.

Recodified from 11:20-7.2 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

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

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

Rewrote (a).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted references to basic and essential health care services plan preceding “in force” throughout; in (b), inserted “and the basic and essential health care services plan policy forms” preceding “written by the member”.

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

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

In (b), deleted references to “policy forms”.

#### 11:20-7.4 Contents of the Loss Ratio Report

(a) A Loss Ratio Report form set forth at Appendix Exhibit J shall be completed by August 15 of each year by each member and shall include the following information with respect to standard health benefits plans and basic and essential health care services plans:

1. The reporting member’s name and address;
2. The member’s net earned premium for the preceding calendar year;
3. A statement of the member’s total losses incurred consisting of:
  - i. Claims paid during the preceding calendar year, regardless of the year incurred;
  - ii. Less residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year;
  - iii. Less claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year as reported in the preceding calendar year’s Loss Ratio Report;
  - iv. Plus claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year;
  - v. Plus residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year;
  - vi. Plus a pro rata share of the reimbursable net paid loss assessment paid by the carrier pursuant to N.J.A.C. 11:20-2.17 during the preceding calendar year, if any, determined as the member’s total net paid loss assessment multiplied by the ratio resulting from dividing the member’s net earned premium for standard health benefits plans and the basic and essential health care services plan for the preceding calendar year by the net earned premiums for all of the member’s health benefits plans for the preceding calendar year;
4. The member’s loss ratio (determined by dividing the total losses incurred in (a)3 above by the net earned premium as determined in (a)2 above);
5. Certification by a member of the American Academy of Actuaries that the information provided in the Report is accurate, complete and that the carrier is in compliance with the requirements of N.J.S.A. 17B:27A-9 in accordance with instructions; and

6. Such other information as the Board may request.

(b) The residual reserve reported in (a) above shall consist of either:

1. A safeharbor reserve equal to 3.3 percent of the sum of (a)3i, (a)3iii and (a)3iv above; or
2. A calculated residual reserve, supported by data and assumptions demonstrating how the reserve was calculated, and an accompanying actuarial certification. A calculated residual reserve may be subject to independent audit by an actuarial firm selected by the Board. If such firm finds that the calculated residual reserve is not reasonable, supportable, or otherwise in conformance with this subchapter, the Board shall not accept the carrier’s loss ratio report or approve a refund plan.

Recodified from 11:20-7.3 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

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

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

In (a), inserted “if any,” in 3vi, and inserted “in (a)3 above” in 4.

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In the introductory paragraph of (a) and in 3vi, inserted “and the basic and essential health care services plan” following “health benefits plan”.

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

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

In the introductory paragraph of (a), added reference to Appendix Exhibit J, substituted “by August 15 of each year” for “annually”, and deleted “the” preceding “basic and essential”.

#### 11:20-7.5 Refund plan

(a) If the loss ratio determined in N.J.A.C. 11:20-7.4 is less than 75 percent, the member shall include with the Report a plan to be approved by the Board for a prompt refund to policy and contract holders of the difference between the amount of net earned premium it received that year on the standard health benefits plans plus net earned premium received that year on basic and essential health care services plans and the amount that would have been necessary to achieve the 75 percent loss ratio.

(b) The refund plan shall conform with the following:

1. Refunds shall be made to all contract holders who were covered for any period during the preceding calendar year whose refund is \$2.00 or greater;
2. The refund amount per contract holder shall be determined by multiplying the earned premium from each contract holder’s standard health benefits plan or basic and essential health care services plan by the percentage resulting from dividing the total refund calculated in accordance with (a) above by the carrier’s total net earned premium from the standard health benefits plans and basic and essential health care services plans, or on the basis of a practical and equitable alternative formula proposed by the carrier for approval by the Board; and

3. Refund payments shall be made within 45 days of written approval by the Board of the refund plan.

(c) The Board may request that a carrier provide additional information or that a carrier make amendments to the refund plan. Carriers shall respond to such requests within the timeframes specified by the Board.

Recodified from 11:20-7.4 and amended by R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

Amended by R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

In (a), inserted "and net earned premium received that year on the basic and essential health care services plan" following "health benefits plan" throughout; in (b)2, inserted references to basic and essential health care plan following "health benefits plan" throughout.

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

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

In (a), substituted "plus" for "and" preceding "net earned premium" and deleted "the" preceding "basic and essential"; in (b)1, inserted "whose refund is \$2.00 or greater" at the end.

### 11:20-7.6 Unclaimed loss ratio refunds

(a) Any loss ratio refund issued by a carrier to a policy or contract holder pursuant to this subchapter which remains unclaimed by that policy or contract holder shall be deemed abandoned one year from the date upon which the Board approves the refund plan.

(b) Refunds deemed abandoned pursuant to (a) above shall be subject to all applicable provisions of the Uniform Unclaimed Property Act, N.J.S.A. 46:30B-1 et seq., including, but not limited to, N.J.S.A. 46:30B-30, 46, 47, 49, 50 and 57. All carriers shall follow the procedures set forth in the Uniform Unclaimed Property Act with respect to the disposition of refunds deemed abandoned.

(c) Carriers which comply with the applicable provisions of the Uniform Unclaimed Property Act and this subchapter shall be relieved of liability to the extent of any unclaimed refunds upon payment of any unclaimed refunds to the State administrator designated pursuant to the Uniform Unclaimed Property Act.

New Rule, R.1996 d.193, effective April 15, 1996.

See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

### 11:20-7.7 Certification of loss ratio refunds

Within 15 days of providing refunds to all policy or contract holders for a specific calendar year, any carrier required to provide a loss ratio refund pursuant this subchapter shall provide a certification to the IHC Board at the address in N.J.A.C. 11:20-2.1 stating the following: "The loss ratio refund, as set forth in the Loss Ratio Report, was issued by to all policy or contract holders eligible for reimbursement with refund checks mailed, or premiums credited, on."

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

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

## SUBCHAPTER 8. THE IHC PROGRAM ASSESSMENT REPORT

### 11:20-8.1 Scope and applicability

(a) This subchapter sets forth reporting and certification requirements for premium and non-group enrollment data of Program members and other carriers with reportable accident and health premium in New Jersey. This subchapter also sets forth reporting and certification requirements for premium, claims, and net investment income data of Program members issuing individual health benefits plans.

(b) This subchapter shall apply to all carriers with reportable accident and health premium in New Jersey for any portion of the two-year calculation period for which reports under this subchapter are required to be filed.

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

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

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

In (a), deleted "annual" preceding "reporting"; and in (b), substituted "two-year calculation period" for "calendar year".

Repeal and New Rule, R.2003 d.91, effective January 28, 2003.

See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Section was "Scope and applicability".

### 11:20-8.2 Filing of the assessment report form

(a) Every carrier with reportable accident and health premium in New Jersey shall file the Exhibit K Assessment Report form, a copy of the Exhibit K Part C Premium Data Worksheet, and a copy of the Exhibit K Part D Enrollment Data Worksheet, which are set forth as Exhibit K in the Appendix to this chapter, incorporated herein by reference, on or before April 1 of the year immediately following every two-year calculation period.

(b) If a carrier with reportable accident and health premium in New Jersey is an affiliated carrier, the Exhibit K Assessment Report, the Part C Premium Data Worksheet and the Part D Enrollment Data Worksheet shall be filed as follows:

1. Each affiliated carrier shall file one copy of the Exhibit K Part C Premium Data Worksheet whether or not that affiliated carrier reported accident and health premium in New Jersey during the two-year calculation period.

2. Each affiliated carrier shall file one copy of the Exhibit K Part D Enrollment Data Worksheet if the carrier issued or renewed any of the coverages specified on the Enrollment Data Worksheet. If an affiliated carrier neither issued nor renewed any of the coverages specified on the Enrollment Data Worksheet, it is not necessary for that affiliated carrier to file the Exhibit K Part D Enrollment Data Worksheet.

3. The combined affiliated carriers, identified using a single carrier name, shall file one copy of the Exhibit K Assessment Report. The information specified on the

SUBCHAPTER 18. WITHDRAWALS OF CARRIERS  
FROM THE INDIVIDUAL MARKET AND THE  
WITHDRAWAL OF PLAN, PLAN OPTION, OR  
DEDUCTIBLE/COPAYMENT OPTION

**11:20-18.1 Purpose and scope**

(a) The purpose of this subchapter is to establish the requirements and procedures by which carriers issuing plans pursuant to the IHC Act may cease doing business in the individual plan market in this State. Additionally, this subchapter establishes the requirements and procedures by which carriers may cease issuing and renewing: all individual plans; a specific plan, by issuing the same plan through a different delivery mechanism; a specific plan option, by offering an alternative approved plan option; or a specific deductible/copayment option that is optional pursuant to N.J.A.C. 11:20-3.1. This subchapter also establishes requirements for carriers in the event that the Board promulgates regulations repealing a specific plan, plan option, or deductible/copayment option.

(b) This subchapter applies to all carriers, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, that seek to cease offering or renewing individual plans issued pursuant to the IHC Act, and carriers that seek to cease issuing a specific standard plan, plan option, or deductible/copayment option as permitted herein, or as directed by the IHC Board.

Amended by R.2006 d.15, effective January 3, 2006.  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

In (a) added "issuing plans pursuant to the IHC Act" following "by which carriers" in the first sentence and added "and renewing" following "may cease issuing" in the second sentence; in (b), added "issued pursuant to the IHC Act" following "plans"; substituted "individual" for "standard individual health benefits" throughout.

**11:20-18.2 Definitions**

Words and terms, when used in this subchapter, shall have the meanings set forth in the Act or at N.J.A.C. 11:20-1.2, unless defined below or unless the context clearly indicates otherwise:

"Cease doing business" for purposes of this subchapter means market withdrawal.

"Individual plan" means a plan developed by the Individual Health Coverage Program Board offered pursuant to N.J.S.A. 17B:27A-4b and the basic and essential health care services plan developed by the Legislature and offered pursuant to P.L. 2001, c.368, including any rider offered with such a plan.

"Pre-reform plan" means an individual health benefits plan issued in New Jersey prior to August 1, 1993.

"State" means the State of New Jersey.

"Market withdrawal" means a carrier's, or one or more affiliated carriers', cessation of the issuance of all individual plans and nonrenewal of all in force individual plans and pre-

reform plans upon their respective anniversary dates without the carrier's offering a replacement with an individual plan, except where such action is taken pursuant to N.J.S.A. 17B:27A-6.

"Plan option withdrawal" means a carrier's cessation of the issuance of an individual plan option, and the nonrenewal of all in force individual plans issued with that option upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A-6 or N.J.A.C. 11:20-18.5.

"Plan withdrawal" means a carrier's cessation of the issuance of one of the individual plans, and the nonrenewal of all in force individual plans of that type upon their respective anniversary dates, except where such action is taken pursuant to N.J.S.A. 17B:27A-6 or N.J.A.C. 11:20-18.5.

Amended by R.2003 d.91, effective January 28, 2003.  
See: 35 N.J.R. 73(a), 35 N.J.R. 1290(a).

Rewrote "Standard individual health benefits plan".  
Amended by R.2006 d.15, effective January 3, 2006.  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote "Cease doing business"; added "Pre-reform plan"; changed "Standard individual health benefits plan" to "Individual plan", "Market withdraw or market withdrawal" to "Market withdrawal", "Plan option withdraw or plan option withdrawal" to "Plan option withdrawal", "Plan withdraw or plan withdrawal" to "Plan withdrawal", and rewrote the definitions.

### 11:20-18.3 Carrier cancellation of individual plans

No carrier with in force individual plans shall cancel an individual plan, except in accordance with N.J.S.A. 17B:27A-6 or, upon the plan's anniversary date, N.J.A.C. 11:20-18.5, 18.6, or 18.7.

Amended by R.2006 d.15, effective January 3, 2006.  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote the section; section was "Carrier cancellation of standard individual health benefits plans".

### 11:20-18.4 Cessation of offer and issuance of individual plans

(a) No carrier with in force individual plans shall cease to offer and issue all of its individual plans to an eligible person unless the Commissioner has determined pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11 that the carrier does not have the financial resources necessary to underwrite additional coverage, and it has provided written notice to:

1. The Board at least 30 days before it intends to cease offering and issuing individual plans. Upon receipt of such notice, the Board shall no longer distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide; and

2. Its individual plan policyholders, in conjunction with each notice of an adjustment of rates provided to such policyholders following the date the carrier ceases to offer and issue such plans. The notice to policyholders shall state that:

- i. The carrier intends to cease offering and issuing individual plans in New Jersey;

- ii. The carrier will continue to renew the policyholder's health benefits plan at the policyholder's option; and

- iii. The policyholder may obtain information about individual health benefits plans offered by other carriers by calling 1-800-838-0935 for a free Individual Health Coverage Program Buyer's Guide or may obtain information on the Department of Banking and Insurance website at: [www.nj.gov/dobi/reform.htm](http://www.nj.gov/dobi/reform.htm).

(b) A carrier that notifies the Board under this section shall continue to renew all in force individual plans until it obtains the Board's approval for market withdrawal in accordance with N.J.A.C. 11:20-18.5.

(c) A carrier that has ceased offering and issuing individual plans pursuant to N.J.S.A. 17B:27A-8b and N.J.A.C. 11:20-11, but has not withdrawn from the market in accordance with N.J.A.C. 11:20-18.5, may resume offering and issuing standard individual health benefits plan to an eligible person after it has notified the Board, in writing, that it intends to resume offering individual plans. Upon receipt of such notice, the Board shall distribute the carrier's filed rates in conjunction with the Individual Health Coverage Program Buyer's Guide.

(d) A carrier with in force individual plans that has ceased to offer and issue all of its individual plans pursuant to this section shall nevertheless continue to comply with all other provisions of the law.

Amended by R.2006 d.15, effective January 3, 2006.  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).

Rewrote the section; section was "Cessation of offer and issuance of standard individual health benefits plans".

### 11:20-18.5 General provisions for market withdrawal

(a) No carrier with in force individual plans, whether or not affiliated with other carriers doing business in the individual plan market in New Jersey, shall refuse to issue or refuse to renew an individual plan, except in accordance with N.J.S.A. 17B:27A-6, or in accordance with N.J.A.C. 11:20-18.4 or 18.6, unless the carrier receives approval from the IHC Board to withdraw all of its individual plans and pre-reform plans in accordance with the provisions of this subchapter.

(b) A carrier that seeks to withdraw shall file with the IHC Board an application for market withdrawal in the format described in (c) below. A carrier with more than one affiliated carrier doing business in the individual plan market in New Jersey may apply for market withdrawal on behalf of one or more affiliated carriers. Until the withdrawal process is complete, the withdrawing carrier shall continue to be governed by N.J.S.A. 17B:27A-2 et seq. and all rules promulgated thereunder, including, but not limited to, the

minimum loss ratio and policyholder refund requirements and liability for a proportionate share of assessments for reimbursable losses and administrative expenses.

(c) The application for market withdrawal shall be sent to the IHC Board at the address set forth in N.J.A.C. 11:20-2.1, and shall include the following information:

1. The name of the carrier seeking to withdraw;
2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for market withdrawal;
3. A statement, describing with specificity, the carrier's reasons for withdrawing from the individual market in this State;
4. A statement of the carrier's percentage market share in the individual plan market, if known, including its most recent policy or contract count and annual amount of direct premium earned and written;
5. A statement indicating whether the carrier has applied for an exemption pursuant to N.J.A.C. 11:20-9 in the two-year calculation period during which the application for market withdrawal application was filed;
6. A copy of the carrier's most recent loss ratio filing submitted pursuant to N.J.A.C. 11:20-7;
7. A copy of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;
8. A statement indicating whether the carrier has any affiliated carriers writing any health benefits plans in this State, the names of such affiliated carriers and the lines of insurance written, and whether any such affiliated carriers will continue to offer individual plans after the carrier's withdrawal;
9. A statement indicating whether the carrier is withdrawing from other lines of business in this State, and if so, the lines from which it is withdrawing, its authority do so, and whether it has sought and obtained approval for such withdrawal;
10. A statement indicating whether the carrier has guaranteed rates to its policyholders and for what period of time;
11. A copy of the proposed nonrenewal notices the applicant intends to send to its policy or contractholders if the application for market withdrawal is approved. Nonrenewal notices for policy or contractholders shall contain the following information:
  - i. That the carrier has elected to withdraw;
  - ii. The date upon which the policy or contract shall be nonrenewed;
  - iii. That the policy or contract is being nonrenewed under the authority of this subchapter;

iv. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan nonrenewal;

vi. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing condition exclusion period of 12 months; and

vii. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage;

12. Copies of the proposed nonrenewal notices the applicant intends to send to its producers if the application for market withdrawal is approved. Nonrenewal notices for producers shall contain the following information:

- i. That the carrier has elected to withdraw;
- ii. The date upon which the policy or contract shall be nonrenewed;
- iii. That the policies or contracts are being nonrenewed under the authority of this subchapter;
- iv. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the plan nonrenewal;
- v. A statement that a person who fails to obtain subsequent individual coverage within 31 days of the nonrenewal may be subject to a pre-existing conditions exclusion period of 12 months;
- vi. A statement that, pursuant to N.J.S.A. 17B:27A-6, all carriers offering individual plans must issue coverage to any individual who requests coverage, meets the eligibility requirements, and pays the required premium for the coverage; and
- vii. The date upon which the carrier will begin to cease the issuance and to nonrenew all individual plans and pre-reform plans; and

13. Any additional information which the carrier believes is relevant for the IHC Board to review the carrier's application for market withdrawal.

(d) The IHC Board shall not begin its evaluation of the application for market withdrawal until the applicant has complied with the requirements contained in this section for its submission.

1. Within 45 days of receipt of an application for market withdrawal or a subsequent amendment thereto,

filed pursuant to (c) above, the IHC Board shall provide written notice to the carrier indicating that the filing is complete or incomplete. If the IHC Board determines that the filing is incomplete, the IHC Board's written notice shall identify the information that was not provided.

2. Following receipt of a complete application for market withdrawal filed pursuant to (c) above, the IHC Board either shall approve or disapprove the application in writing within 60 days of the date of the IHC Board's written notice to the carrier indicating that the filing is complete.

i. In determining whether to approve or disapprove a carrier's application for market withdrawal, the IHC Board shall consider the following factors:

(1) Whether a sufficient number of carriers necessary to sustain a competitive market would continue to offer individual health benefits plans following the carrier's withdrawal;

(2) Whether the withdrawing carrier's policy or contract holders would be able to replace their health benefits plan with the same or similar plan offered by another carrier at a comparable rate;

(3) Whether the withdrawing carrier reported net paid losses in the preceding calendar year;

(4) Whether a carrier's anticipated losses in the current calendar year would jeopardize its financial solvency;

(5) Whether an affiliated carrier intends to continue to offer individual health benefits plans;

(6) Whether the withdrawing carrier intends to continue to offer health benefits plans in New Jersey, or in other states; and

(7) Any other factors deemed relevant and appropriate by the Board.

3. The Board shall approve an application for market withdrawal unless it determines, based on the factors listed in (d)2i(1) through (7) above, that the carrier's withdrawal would be unjust, unfair, inequitable, or contrary to law or public policy.

i. If the Board approves an application for market withdrawal, the Board shall notify the carrier in writing and the carrier shall proceed to institute a withdrawal pursuant to (e) below.

ii. If the Board disapproves an application for market withdrawal, the Board shall provide, in writing, the reasons for the disapproval. A carrier may appeal the Board's determination and request a hearing within 20 days of receipt of written notification of the Board's final determination, pursuant to the procedures set forth in N.J.A.C. 11:20-20.2.

(e) A carrier that has received approval of its application for market withdrawal shall:

1. Not more than 60 days after the date of the Board's approval letter, cease issuing individual plans;

2. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and with the same content submitted to and approved by the IHC Board pursuant to (c)11 above, to every individual plan and pre-reform plan policy or contractholder, informing the policy or contractholder that the policy or contract will be nonrenewed on the anniversary date. This initial notice to each policy or contractholder shall include a copy of the Individual Health Coverage Buyer's Guide and current premium comparison chart. A carrier shall begin to send notices of nonrenewal not more than 60 days after the date of the Board's approval letter;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each individual plan and pre-reform plan policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or where no monthly premium statement is transmitted, at least 30 days prior to nonrenewal;

4. Not less than 180 days in advance of the effective date of the nonrenewal on the anniversary date of the policy or contract, mail a notice, in the same format and the same content submitted to and approved by the IHC Board pursuant to (c)12 above, to the producer of record, if any, for each policy or contract; and

5. Not more than 10 days after receipt of the Board's approval letter, send a letter to the IHC Board at the address in N.J.A.C. 11:20-2.1, requesting to purchase copies of the IHC Program Buyer's Guide and price comparison and requesting a quantity sufficient to comply with the requirement that each policy or contract holder receive a copy of the Buyer's Guide and current premium comparison chart with the initial notice of nonrenewal. Alternatively, the carrier may arrange to obtain from the IHC Board a copy of the Buyer's Guide and price comparison to reproduce at its own cost a sufficient quantity of copies. Carriers shall not alter the text or format of the Buyer's Guide or premium comparison chart in any way.

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

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

Rewrote the section.

#### **11:20-18.6 General provisions for withdrawal of plan, plan option, or deductible/copayment option**

(a) No carrier shall cease to issue or nonrenew an individual plan, plan option, or deductible/copayment option required or permitted to be offered by N.J.A.C. 11:20-3.1, except in accordance with N.J.S.A. 17B:27A-6 or N.J.A.C.

11:20-18.5, until the carrier submits a notice of intent to withdraw a plan, plan option, or deductible/copayment option with the IHC Board in accordance with the provisions of this subchapter.

(b) A carrier may cease to issue and nonrenew an individual plan pursuant to this section only if:

1. The deductible/copayment option is not required to be offered pursuant to N.J.A.C. 11:20-3.1(b); or

2. In the case of a deductible/copayment option required to be offered pursuant to N.J.A.C. 11:20-3.1, the carrier meets its obligations to offer all four standard individual plans and required deductible/copayment options either by offering the plans as indemnity plans or by making the plan or plans available through or in conjunction with a selective contracting arrangement to all New Jersey residents.

(c) A carrier may cease to issue and nonrenew a standard plan option pursuant to this section by offering another approved plan option. Examples of plan options include, but are not limited to, a carrier's option to offer autologous bone marrow transplant coverage in either the policy or contract or in a rider, and an HMO's option to offer plans subject to deductible and coinsurance provisions.

(d) A carrier that seeks to withdraw a plan, plan option, or deductible/copayment option pursuant to this section shall provide the IHC Board with written notification of its intent to withdraw a plan, plan option, or deductible/copayment option. The notice of intent to withdraw a plan, plan option, or deductible/copayment option shall be sent to the IHC Board at the address set forth in N.J.A.C. 11:20-2.1, and shall include the following information:

1. The name of the carrier;

2. The name, address, telephone number, and fax number of the carrier's representative responsible for the application for plan or plan option withdrawal;

3. A specific description of the reasons the carrier is withdrawing the plan, plan option, or deductible/copayment option;

4. A statement of the number of in force plans affected by the withdrawal;

5. Copies of the carrier's most recent enrollment status report filed pursuant to N.J.A.C. 11:20-17;

6. Copies of a nonrenewal notice the applicant intends to send to its policy or contractholders. Nonrenewal notices for policy or contractholders shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

ii. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

iii. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

iv. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

v. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

vi. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the plan, plan option, or deductible/ copayment option withdrawal; and

7. Copies of the proposed nonrenewal notices the applicant intends to send to its producers. Nonrenewal notices for producers shall contain the following information:

i. A statement that the carrier has elected to nonrenew the plan, plan option, or deductible/copayment option;

ii. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

iii. That the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

iv. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

v. The name, address and telephone number of the employee or agent of the carrier who may be contacted for assistance and information regarding the withdrawal; and

vi. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

(e) The IHC Board shall review the notice of intent to withdraw a plan, plan option, or deductible/copayment option to determine whether it complies with the filing requirements of (d) above. The IHC Board shall notify the carrier, in writing, of any deficiencies and the requirements which are necessary to bring it into compliance with this section.

(f) A carrier which has submitted a notice of intent to withdraw a plan, plan option, or deductible/copayment option shall:

1. Not more than 60 days after the date of notice of intent to withdraw the plan, plan option, or deductible/co-

payment option cease issuing the individual plan, plan option, or deductible/copayment option;

2. Not more than 60 days following the date of notice of intent to withdraw the plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, plan option, or deductible/copayment option, mail a notice, in the same format submitted to the IHC Board pursuant to (d)6 above, to every policy or contractholder, informing the policy or contractholder that the plan, plan option, or deductible/copayment option will be nonrenewed on the anniversary date;

3. Following the initial notice to each policy or contractholder, send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to nonrenewal; and

4. Not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan or plan option, or deductible/copayment option, mail a notice, in the same format submitted to the IHC Board pursuant to (d)7 above, to the producer of record, if any, for each policy or contract.

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

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

Rewrote the section; section was "General provisions for withdrawal of plan, plan option, optional rating tier, or deductible/copayment option".

#### **11:20-18.7 Plan or plan option withdrawal by IHC Board**

(a) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall cease issuing that plan, plan option, or deductible/copayment option within 90 days after the rules take effect.

(b) If the IHC Board promulgates rules withdrawing a plan, plan option, or deductible/copayment option, a carrier shall nonrenew that individual plan, plan option, or deductible/copayment option pursuant to the procedures set forth in (c) and (d) below.

(c) Not more than 60 days after the Board has promulgated rules withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal by mail to every policy or contractholder. Following the initial notice of nonrenewal to each policy or contractholder, the carrier shall send a subsequent notice of the nonrenewal to each policy or contractholder which notice shall be included with a monthly premium bill or premium notice issued prior to the date of nonrenewal, or, where no monthly premium statement is transmitted, send a notice at least 30 days prior to

nonrenewal. Nonrenewal notices for policy or contractholders shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. A statement that the policy or contractholder may contact his or her producer, if any, for additional information regarding the plan, plan option, or deductible/copayment option withdrawal; and

6. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal.

(d) Not more than 60 days after the Board has promulgated regulations withdrawing a plan, plan option, or deductible/copayment option, and not less than 90 days in advance of the effective date of the nonrenewal on the anniversary date of the plan, a carrier shall mail a notice of nonrenewal to the producer of record, if any, for each policy or contract. Nonrenewal notices for producers shall contain the following information:

1. A statement that the IHC Board has withdrawn the plan, plan option, or deductible/copayment option from the individual health benefits market;

2. The date upon which the plan, plan option, or deductible/copayment option shall be nonrenewed;

3. A statement that the plan, plan option, or deductible/copayment option is being nonrenewed under the authority of this subchapter;

4. A notice that the carrier shall make available a replacement plan, plan option, or deductible/copayment option;

5. The name, address and telephone number of the employee of the carrier who may be contacted for assistance and information regarding the withdrawal; and

6. The date upon which the carrier will begin to cease the issuance of the plan, plan option, or deductible/copayment option.

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

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

Substituted "individual" for "standard individual health benefits" and deleted references to "optional rating tier" throughout.

**11:20-18.8 Restrictions on writings**

A carrier that ceases to do business pursuant to N.J.A.C. 11:20-18.5 shall be prohibited from writing new individual plans in New Jersey for a period of five years beginning on the termination date of the last standard individual health benefits plan not renewed.

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

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

Substituted "individual" for "standard individual health benefits".

**11:20-18.9 Other policy or contractholder rights unaffected**

Nothing in this subchapter shall be construed to contravene any rights of policy or contractholders concerning other obligations set forth in a policy or contract issued by a carrier.

Recodified from N.J.A.C. 11:20-18.10 by R.2006 d.15, effective January 3, 2006.

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

Former N.J.A.C. 11:20-18.9, Penalties, repealed.

**11:20-18.10 (Reserved)**

Recodified as N.J.A.C. 11:20-18.9 by R.2006 d.15, effective January 3, 2006.

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

Section was "Other policy or contractholder rights unaffected".

5. A caption at the top of the document identifying it as a petition for rulemaking pursuant to N.J.S.A. 52:14B-4(f) and this subchapter.

(b) The petition shall be sent to the Executive Director at the address in N.J.A.C. 11:20-2.1(h).

(c) Within 30 days of its receipt of a petition for rulemaking, the Board shall review the same to ascertain if the submission complies with the requirements of (a) above and, in the event that the Board determines that the submission is not in substantial compliance with (a) above, the Board shall notify the petitioner of such noncompliance and of the particular deficiency or deficiencies in the submission on which the decision of the Board was based. The Board shall also advise the petitioner that any deficiencies may be corrected and the petition may be resubmitted for further consideration.

(d) Any document submitted to the Board which is not in substantial compliance with (a) above shall not be deemed to be a petition for rulemaking requiring further Board action pursuant to N.J.S.A. 52:14B-4(f).

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

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

Rewrote (a), recodified (b)-(c) as (c)-(d), added new (b); in former (c), substituted "rulemaking" for "a rule".

**11:20-19.3 Procedure of the Board**

(a) Upon receipt of a petition in compliance with N.J.A.C. 11:20-19.2, the Board shall file, within 15 days, a notice of petition with the Office of Administrative Law for publication in the New Jersey Register. The notice shall include:

1. The name of the petitioner;
2. The substance or nature of the rulemaking action which is requested;
3. The problem or purpose which is the subject of the request; and
4. The date the petition was received.

(b) Within 60 days of receiving the petition in compliance with N.J.A.C. 11:20-19.2, the Board shall mail to the petitioner, and file with the Office of Administrative Law for publication in the New Jersey Register, a notice of action on the petition which shall include:

1. The name of the petitioner;
2. The New Jersey Register citation for the notice of petition, if that notice appeared in a previous New Jersey Register;
3. Certification by the Board that the petition was duly considered pursuant to law;
4. The nature or substance of the Board's action upon the petition; and

**SUBCHAPTER 19. PETITIONS FOR RULEMAKING****11:20-19.1 Scope**

This subchapter shall apply to all petitions to the Board by interested persons to adopt a new rule, or amend or repeal any existing rule by the Board, pursuant to N.J.S.A. 52:14B-4(f).

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

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

Rewrote the section.

**11:20-19.2 Procedure for petitioner**

(a) Any person who wishes to petition the Board to adopt a new rule or amend or repeal any existing rule shall submit to the Board, in writing, the following information:

1. Name, address, phone, fax, and email address of the petitioner;
2. The substance or nature of the rulemaking which is requested, which may include suggested text of the proposed new rule, amended rule or repealed rule;
3. The reasons for the request and the petitioner's interest in the request;
4. References to the statutory authority of the Board to take the requested action; and

5. A brief statement of reasons for the Board's action.

(c) The Board's action on a petition may include:

1. Denying the petition and providing a written statement of the Board's reasons to the petitioner, and including such reasons in its notice of action;

2. Granting the petition and initiating a rulemaking proceeding within 90 days of the granting of the petition; or

3. Referring the matter for further deliberations which shall be concluded within 90 days of referring the matter for further deliberations. Upon conclusion of such further deliberations, the Board shall either deny the petition and provide a written statement of its reasons or grant the petition and initiate a rulemaking proceeding within 90 days.

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

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

In (b), revised the timeframe in which the Board shall respond to a petition for rulemaking from 30 to 60 days; rewrote (c).

## SUBCHAPTER 20. APPEALS FROM ACTIONS OF THE BOARD

### 11:20-20.1 Scope

This subchapter shall apply to all appeals from Board determinations and requests for hearing as expressly provided pursuant to this chapter.

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

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

Rewrote the section.

### 11:20-20.2 Appeals procedures

(a) A member may request a hearing on a final determination by the Board within 20 days from the date of receipt of such final determination as expressly permitted by this chapter as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, daytime telephone number, and fax number of a contact person familiar with the matter;

ii. A copy of the Board's determination;

iii. A statement requesting a hearing; and

iv. A concise statement listing the disputed adjudicative facts warranting a hearing and describing the basis for the member's contention that the Board's findings of fact are erroneous.

2. The Board, after receipt of a properly completed request for a hearing, may provide for an informal conference between the member and the staff and/or members of the Board, to determine whether there are disputed adjudicative facts.

3. The Board shall, within 30 days of a properly completed request for a hearing, determine whether the matter constitutes a contested case pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

i. If the Board finds that the matter constitutes a contested case, it may transmit the matter to the Office of Administrative Law for a hearing consistent with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

ii. If the Board finds that the matter does not constitute a contested case, it may, with the approval of the Director of the Office of Administrative Law, transmit the matter to the Office of Administrative Law for a hearing consistent with N.J.A.C. 1:1-21.

iii. If the Board finds that there are no good-faith disputed adjudicative facts and the matter may be decided on the documents filed, the Board may notify the applicant in writing as to the final disposition of the matter.

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

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

In (a), rewrote the introductory paragraph and iv; in (a)2, substituted "disputed adjudicative facts" for "material issues of fact in dispute"; in (a)3, substituted "30" for "45" in the introductory paragraph, rewrote i and ii, and added iii.

## SUBCHAPTER 21. (RESERVED)

## SUBCHAPTER 22. BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN

### 11:20-22.1 Purpose and scope

(a) This subchapter implements provisions of P.L. 2001, c.368 (N.J.S.A. 17B:27A-4.4 through 4.7), an Act that supplements the Individual Health Insurance Reform Act, P.L. 1992, c. 161. This subchapter establishes procedures and standards for carriers to meet their obligations under P.L. 2001, c.368, and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the P.L. 2001, c.368. The other subchapters in this chapter should be consulted for procedures and standards that also have application to the basic and essential health care services plan required by P.L. 2001, c.368.

(b) The provisions of this subchapter shall be applicable to all carriers that are members of the Individual Health Coverage Program, as the term "member" is defined in N.J.A.C. 11:20-1.2 and N.J.S.A. 17B:27A-2.

(c) The provisions of this subchapter shall be applicable to the marketing, sale, issue and administration of all basic and essential health care services plans.

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

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

In (a), in the last sentence, substituted "The" for "Carriers should consult the" and added "should be consulted" following "in this chapter"; in (b), added quotes around the word "member" and changed the N.J.A.C. reference; in (c), deleted "on or after January 1, 2003" at the end of the paragraph.

### 11:20-22.2 Definitions

Words and terms contained in N.J.S.A. 17B:27A-2 et seq., when used in this chapter, shall have the meanings as defined in the N.J.S.A. 17B:27A-2 et seq., and N.J.A.C. 11:20-1.2 unless the context clearly indicates otherwise, or as such words and terms are further defined by this subchapter, as follows:

"Copayment" means a specified dollar amount which a person covered under a basic and essential health care services plan must pay for certain charges covered under such plan. A covered person may be required to pay an amount in excess of the copayment if the charge the provider bills exceeds the reasonable and customary charge.

"Good faith effort" means the demonstrated efforts a carrier undertakes to make the basic and essential health care services plan available to residents of New Jersey, as evaluated by the Board pursuant to the standards set forth in this subchapter.

"Modified community rated" means that the premium for all persons covered under a health benefits plan contract is the same, based on the experience of all persons covered by that contract, except that a rate differential may be applied on the basis of age, gender and geography, as detailed in section 2.c of P.L. 2001, c.368, and in this subchapter.

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

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

In the introductory paragraph, updated the N.J.A.C. reference.

### 11:20-22.3 Obligation to offer a basic and essential health care services plan

(a) Every member that writes individual health benefits plans in New Jersey shall offer the basic and essential health care services plan.

(b) Members that write individual health benefits plans as HMO coverage and as indemnity coverage may choose to offer the basic and essential health care services plan as an HMO plan or as an indemnity plan and are not required to write the plan as both an HMO plan and as an indemnity plan. Carriers that choose to offer the basic and essential health care services plan as an indemnity plan may include provisions to create an indemnity-based preferred provider organization (PPO) plan or an exclusive provider organization (EPO) plan.

### 11:20-22.4 Filing the basic and essential health care services plan policy form

(a) Before a member may offer or issue the basic and essential health care service plan policy form, the member

shall submit the information set forth below to the Board at the address specified at N.J.A.C. 11:20-2.1(h):

1. One copy of the policy form for the basic and essential health care services plan, unless filing a certification as set forth in (b)1 below;

2. A certification signed by a duly authorized officer of the member that states that:

i. The member will make the basic and essential health care services plan available to eligible persons and will make a good faith effort to market the plan; and

ii. Rates for the basic and essential health care services plan have been submitted pursuant to the requirements of N.J.A.C. 11:20-6; and

iii. The benefits in the policy form being submitted include all of the coverages enumerated in section 2.a. of P.L. 2001, c.368, but do not include any additional benefits.

(b) The Board makes available to members a specimen policy form for the basic and essential health care services plan, set forth in chapter Appendix Exhibit F, incorporated herein by reference. The Board has determined that the plan set forth in Exhibit F includes the coverages required for a basic and essential health care services plan.

1. Members that choose to use the plan specimen policy form as set forth in Exhibit F shall submit, in lieu of a copy of the basic and essential health care services plan policy form, a Certification, signed by a duly authorized officer of the company, stating that the Company is using the basic and essential health care services plan specimen policy form as included in Exhibit F, including the carrier name, and similar variable text, as appropriate. The Certification regarding use of the specimen policy form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

2. Members that choose to use the plan specimen policy form as set forth in Exhibit F with some modifications to the text shall submit the form, redlined to show any differences between the submitted form and the form as contained in Exhibit F. The redlined text of the form shall be submitted with the information set forth in N.J.A.C. 11:20-22.4(a).

(c) The Board shall notify a member in writing of its determination whether the policy form filing is approved within 30 days of the date the filing is received. If the Board does not notify a member of its determination with respect to the filing within 30 days of the date the filing is received, the filing shall be deemed approved.

Amended by R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).

See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

In (a)2i and ii, added "and" at the end; in (b), substituted "Exhibit F" for "Exhibit V" and "Exhibit E" throughout".

EXHIBIT E

CERTIFICATION OF COMPLIANCE WITH INDIVIDUAL HEALTH COVERAGE PLANS

In accordance with N.J.A.C. 11:20-3.2, submit this form, upon entry into the market and by March 1 of every year, to the IHC Board at the address specified at N.J.A.C. 11:20-2.1. Carriers must complete the certification as set forth in this Exhibit; the words in the certification may not be altered.

1. INFORMATION ABOUT THE CARRIER AND RESPONDENT

Carrier Name: \_\_\_\_\_ NAIC #: \_\_\_\_\_

Respondent Information:

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

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ FAX: \_\_\_\_\_ Email address: \_\_\_\_\_

2. COMPLIANCE

Check the appropriate response(s).

\_\_\_\_\_ (a) Plans A/50, B, C, and D comply fully with the IHC Board's individual health benefits plans forms and Explanation of Brackets set forth at Exhibits A and C of the Appendix to N.J.A.C. 11:20.

\_\_\_\_\_ (b) The HMO Plan complies fully with the IHC Board's individual health benefits plans form and Explanation of Brackets set forth at Exhibits B and C of the Appendix to N.J.A.C. 11:20.

3. PLAN OPTIONS AND VARIABLES

Complete each relevant section. Attach additional pages as necessary.

(a) Plans A/50 through D

On the attached worksheet for Plans A/50 through D, provide information regarding all of the plans carrier makes available using Plans A/50 through D. Add or delete rows under each plan designation, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.

**Delivery System:** Identify whether each plan is sold as Traditional Indemnity (Designate as Indem) or Preferred Provider Organization (Designate as PPO).

**Copayment:** For all plans that use a copayment, specify the applicable copayments for Physician Visits, Maternity, specialist and outpatient surgery.

**Deductible:** List the available deductible options. Indemnity plans as well as PPO plans that use a common deductible should list that amount under the Indemnity/Common column. PPO plans that use separate deductible for network and non-network services should list such dollar amounts under the appropriate column headings

**Coinsurance:** List the available policyholder coinsurance options as specific percentages. Indemnity plans as well as PPO plans that use a common coinsurance should list that amount under the Indemnity/Common column. PPO plans that use separate coinsurance for network and non-network services should list such percentages under the appropriate column headings.

1. Do contracts provide for direct payment to health care practitioners without assignment?  Yes  No

2. Specify how coverage for autologous bone marrow transplants is offered.

Plan benefit; or  Rider benefit

(b) HMO Plans

On the attached worksheet for HMO Plans, provide information regarding all of the plans carrier makes available using the HMO plan. Add or delete rows under each plan type, and provide all applicable information regarding each offering of each plan. Refer to N.J.A.C. 11:20-3.1 for information regarding permissible options.

**Copayment:** Specify the applicable copayments for Physician Visits, Maternity, specialist visit and outpatient surgery.

**Deductible:** List the available deductible options as specific amounts

**Coinsurance:** List the available policyholder coinsurance options as specific percentages.

1. Specify how coverage for autologous bone marrow transplants is offered.

Plan benefit; or  Rider benefit

4. CERTIFICATION

I, the Undersigned, certify that this completed form is true and accurate, and that I am an officer of the carrier duly authorized to submit this certification.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

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

Plans A/50 through D											
Plan	Delivery System	Copayment				Deductible			Coinsurance		
		Physician Visit	Maternity	Specialist	Outpatient Surgery	Indemnity or Common	Network	Non-Network	Indemnity or Common	Network	Non-Network
A/50											
B											
C											
D											

HMO Plans					
Physician Visit	Copayment			Deductible	Coinsurance
	Maternity	Specialist	Outpatient Surgery		

Amended by 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).  
Petition for Rulemaking.  
See: 26 N.J.R. 5120(b).  
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).  
Amended by R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).  
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).  
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).  
Amended by 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).  
Repeal and New Rule, R.2006 d.15, effective January 3, 2006 (operative July 1, 2006).  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a), 1005(a).

**EXHIBIT F**

**Notice of Right to Examine [Policy].** Within 30 days after delivery of this [Policy] to You, You may return it to Us for a full refund of any Premium paid, less benefits paid. The [Policy] will be deemed void from the beginning.

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[CARRIER]

**INDIVIDUAL BASIC AND ESSENTIAL HEALTH CARE SERVICES PLAN**

As required by P.L. 2001, c. 368

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**EFFECTIVE DATE OF [POLICY]:** [January 1, 2009]

**Renewal Provision.** Subject to all [Policy] terms and provisions, including those describing Termination of the [Policy], You may renew and keep this Policy in force by paying the premiums as they become due. We agree to pay benefits under the terms and provisions of this Policy.

In consideration of the application for this [Policy] and of the payment of premiums as stated herein, We agree to pay benefits in accordance with and subject to the terms of this [Policy]. This [Policy] is delivered in New Jersey and is governed by the laws thereof.

This [Policy] takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

THIS POLICY IS A LIMITED BENEFITS PLAN AND DOES **NOT** PROVIDE COMPREHENSIVE MAJOR MEDICAL COVERAGE

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

**TABLE OF CONTENTS****Section****Page****DEFINITIONS****ELIGIBILITY****COVERAGE SCHEDULE****[CONTINUATION OF CARE]****BENEFIT DEDUCTIBLES, COPAYMENTS AND COINSURANCE****COVERED CHARGES****UTILIZATION REVIEW****SPECIALTY CASE MANAGEMENT****EXCLUSIONS****[CLAIMS PROCEDURES]****APPEALS PROCEDURE****GRIEVANCE PROCEDURE****[MEMBER PROVISIONS]****COORDINATION OF BENEFITS WITH MEDICARE****SERVICES FOR AUTOMOBILE RELATED INJURIES****GENERAL PROVISIONS**

**EXHIBIT J**

Loss Ratio Report Form  
New Jersey Individual Health Coverage Program

Reporting Year \_\_\_\_\_, for the Preceding  
Calendar Year Ending December 31, \_\_\_\_\_

Name of Carrier: \_\_\_\_\_ NAIC # \_\_\_\_\_

Address: \_\_\_\_\_

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20-7, before you complete this Report.

- A. Net Earned Premium for Standard Health Benefits Plans \$ \_\_\_\_\_
- B. Total Losses Incurred (1-2-3+4+5+6) = \$ \_\_\_\_\_
  - 1. Claims paid during the preceding calendar year regardless of the year incurred; \$ \_\_\_\_\_
  - 2. Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year; \$ \_\_\_\_\_
  - 3. Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the of the preceding calendar year as reported in the preceding calendar year's loss ratio report; \$ \_\_\_\_\_
  - 4. Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; \$ \_\_\_\_\_
  - 5. Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year; \$ \_\_\_\_\_
  - 6. Pro-rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20-2.17; [i x (ii ÷ iii)] = \$ \_\_\_\_\_
    - i. Total net paid loss assessment \$ \_\_\_\_\_
    - ii. Net earned premium for standard health benefits plans \$ \_\_\_\_\_
    - iii. Net earned premium for all health benefits plans \$ \_\_\_\_\_
- C. Loss Ratio (B ÷ A) = \_\_\_\_\_ (If less than 75%, fill out D and E below)
- D. Amount entered on line B ÷ .75 = \$ \_\_\_\_\_
- E. Amount to be refunded to policy or contract holders (A - D) = \$ \_\_\_\_\_

If the amount entered on line C is less than 75%, you must attach to this Report a refund plan that conforms with N.J.A.C. 11:20-7.5. Please submit this form and a refund plan to the address listed in N.J.A.C. 11:20-2.1(h).

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 27A-9e(1) and (2) and N.J.A.C. 11:20-7.

\_\_\_\_\_  
Actuary's Signature

\_\_\_\_\_  
Actuary's Name (Please print clearly)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
**Facsimile Number**

Amended by R.1996 d.193, effective April 15, 1996.  
See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(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.2006 d.15, effective January 3, 2006.  
See: 37 N.J.R. 2994(a), 38 N.J.R. 311(a).