

initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which We expect to render the final decision.

c) If a claim is denied, We will provide the plan administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid. and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d) We will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, We will render a decision as soon as possible. but no later than 120 days after receiving the request. We will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.]

New Rule, R.1996 d.199, effective April 15, 1996.

See: 28 N.J.R. 1661(a), 28 N.J.R. 2010(a).

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Amended by R.1997 d.501, effective January 1, 1998.

See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

Amended by R.1998 d.299, effective September 1, 1998.

See: 30 N.J.R. 1883(a), 30 N.J.R. 2223(a).

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT K

**PART 1
EXPLANATION OF BRACKETS-POLICY AND CERTIFICATE FORMS**

(Plans A,B,C,D,E)

All text which is enclosed in brackets [] is variable. Enclosure in Brackets does not give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

- a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
- b) Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
- c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
- d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
- e) Some areas of variability are determined by the election made by a Carrier.
- f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
- g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO or POS)
- h) Some areas of variability, as set forth in text preceded by "DC" are used solely when the carrier is issuing a Dual Contract POS product.

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective contracting Arrangement, commonly known as PPO or POS plans, explicit guidance is set forth in item 16 below. Similarly, explicit guidance for the issuance of a Dual Contract POS product is set forth in item 17 below. Carriers that issue a Dual Contract POS product should refer to the Explanation of Brackets (HMO Plan), set forth in Part 2 of Exhibit K, for guidance on the variable text that appears in the HMO form that would be issued in conjunction with the indemnity form to produce the Dual Contract POS Plan.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. If a Carrier elects to provide for BOTH a family deductible and family Co-Insurance Cap allowing for an aggregate satisfaction as opposed to an individual satisfaction, the variable schedule text addressing individual satisfaction would be deleted. The appropriate multiple of the individual deductible and Co-Insurance Cap must be included. The BENEFIT PROVISION of the HEALTH BENEFITS INSURANCE provision includes text for both an individual and an aggregate satisfaction. Carriers should include text consistent with the text included on the Schedule. **Note:** ALL plans issued by a Carrier MUST include the same option.
4. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
5. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy - Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
8. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
9. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
10. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
11. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
12. If the plan being issued is an indemnity plan, Co-Insurance Cap text should be included. If the plan being issued is a PPO or POS plan, Coinsured Charge Limit text should be included.
13. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy. **NOTE:** A Carrier may make separate elections regarding the optional benefit for Plan A and B-E to either include as part of the standard plans or offer as a rider.

- 22) Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
- 23) The "Notice of Loss" section of the "Claims Provisions" may be omitted, at the option of the Carrier.
- 24) The third sentence of the "Payment of Claims" section of the "Claims Provisions" should be omitted, if not applicable.
- 25) Carriers may elect to omit the ERISA provisions.

The following explanations apply only to the Evidence of Coverage.

- 1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
- 2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
- 3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.

New Rule, R.1997 d.62, effective February 3, 1997.

See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).

Amended by R.1997 d.280, effective July 7, 1997 (operative September 1, 1997).

See: 29 N.J.R. 1090(a), 29 N.J.R. 2931(a).

Amended by R.1997 d.501, effective January 1, 1998.

See: 29 N.J.R. 4620(a), 29 N.J.R. 5069(a).

Amended by R.1998 d.512, effective September 25, 1998.

See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).

EXHIBIT KK

THE NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM
CERTIFICATION OF NON-MEMBER STATUS

Carrier Name _____

Address _____

NAIC # _____

I, (print or type name) _____, a duly authorized officer of the above named entity, hereby certify that this entity:

(CHECK EITHER # 1 OR #2)

1. Is not a "carrier" authorized to issue "health benefits plans" in New Jersey, as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17; or

2. Is a carrier that is not a "member" of the New Jersey Small Employer Health Benefits Program because it had no "health benefits plan" in force in 1997 covering a New Jersey "small employer," as those terms are defined at N.J.A.C. 11:21-1.2 and N.J.S.A. 17B:27A-17. The accident and health premiums reported to the New Jersey Department of Banking and Insurance by this carrier for 1997 were entirely attributable to the following types of coverage, all of which are not included in, or are expressly excluded from, the definition of "health benefits plan" in the rule cited above (YOU MUST, IN THE SPACES BELOW, SHOW WHY THE REPORTED A&H PREMIUM IS NOT SUBJECT TO ASSESSMENT IN ORDER FOR THIS CERTIFICATION TO BE APPROVED):

1. _____
2. _____
3. _____
4. _____
5. _____

(PLEASE NOTE: CARRIERS THAT COVER NEW JERSEY SMALL EMPLOYERS THROUGH ASSOCIATIONS, TRUSTS, OR MULTIPLE EMPLOYER ARRANGEMENTS ARE MEMBERS OF THE PROGRAM SUBJECT TO ASSESSMENT. IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL (609) 633-1887.

Signature of officer _____	Date _____
Title _____	Telephone Number _____
	Fax Number _____

MAIL COMPLETED FORM TO: New Jersey Small Employer Health Benefits Program
PO Box 325
Trenton, NJ 08625-0325

New Rule, R.1997 d.62, effective February 3, 1997.
See: 28 N.J.R. 4344(a), 29 N.J.R. 428(a).
Administrative correction.

See: 30 N.J.R. 1047(a).
Amended by R.1998 d.512, effective September 25, 1998.
See: 30 N.J.R. 2815(a), 30 N.J.R. 3840(a).