

CHAPTER 22
HEALTH BENEFIT PLANS

Authority

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

Source and Effective Date

R.2006 d.199, effective April 26, 2006.
See: 37 N.J.R. 3779(a), 38 N.J.R. 2499(b).

Chapter Expiration Date

Chapter 22, Health Benefit Plans, expires on April 26, 2011.

Chapter Historical Note

Chapter 22, Health Benefit Plans, was adopted as R.2000 d.452,
effective November 6, 2000. See: 32 N.J.R. 2860(a), 32 N.J.R. 4014(a).

Subchapter 1, Prompt Payment of Claims, was adopted as new rules
by R.2001 d.13, effective January 2, 2001. See: 32 N.J.R. 1985(a), 33
N.J.R. 105(a).

Chapter 22, Health Benefit Plans, was readopted by R.2006 d.199,
effective April 26, 2006. See: Source and Effective Date. See, also,
section annotations.

Subchapter 8, Health Insurance Identification Cards, was adopted as
new rules by R.2009 d.333, effective November 2, 2009 (operative July
1, 2010). See: 40 N.J.R. 6527(a), 41 N.J.R. 4117(b).

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SUBCHAPTER 1. PROMPT PAYMENT OF CLAIMS

11:22-1.1 Purpose and scope

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

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

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

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

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

11:22-1.2 Definitions

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

"ADR" means alternate dispute resolution.

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

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

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

"Commissioner" means the Commissioner of Banking and Insurance.

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

"Clean claim" means:

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

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

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

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

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

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

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

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

"Department" means the Department of Banking and Insurance.

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

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

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

“Organized delivery system” or “ODS” means an organized delivery system that is either certified or licensed pursuant to N.J.S.A. 17:48H-1 et seq.

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

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

Added (b).

11:22-1.3 Acknowledgement of receipt of claims

(a) A carrier or its agent shall acknowledge receipt of all claims. The acknowledgement shall include the date the carrier or its agent received the claim.

1. If a claim is submitted by electronic means, the claim shall be acknowledged electronically no later than two working days following receipt of the claim. The

acknowledgement of receipt of an electronic claim shall go to the entity from which the carrier received the claim.

2. If a claim is submitted by written notice, the claim shall be acknowledged no later than 15 working days following receipt of the claim.

(b) If a carrier or its agent remits payment within two working days of receipt of a claim submitted electronically, or 15 working days of receipt of a claim submitted by written notice, and such payment includes the date of receipt of the claim, the payment shall constitute acknowledgement of receipt.

(c) If a carrier offers providers web-based access to claims status, the available information shall include the date of receipt of the claims. Such information, if posted within the timelines established in (a)2 above, shall constitute acknowledgement of receipt of those claims.

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

“Department” means the Department of Banking and Insurance.

“Health benefits plan” means an individual or group contract issued by a carrier that provides hospital and medical expense benefits or services. Health benefits plan does not include the following types of policies or contracts: health benefit plans subject to N.J.S.A. 17B:27A-2 et seq. (Individual Health Coverage Program) or N.J.S.A. 17B:27A-17 et seq. (Small Employer Health Program); accident only, credit, disability, hospital confinement indemnity, long-term care, vision only, dental only, prescription only, CHAMPUS supplement, Medicare supplement, coverage for Medicare services pursuant to a contract with the United States government, coverage for Medicaid services pursuant to a contract with the State, coverage arising out of a workers’ compensation or similar law, automobile medical payment insurance or other liability-based medical payment insurance, or personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq.

“Health care provider” or “provider” means an individual or entity which, acting within the scope of its license or certification, provides a covered service or supply as defined by the health benefits plan. Health care provider includes, but is not limited to, the health professions specified in N.J.S.A. 17B:48E-12, N.J.S.A. 17B:27-50 and N.J.S.A. 17B:27-51.1a.

“Health wellness promotion program” means services or benefits for services rendered by a health care provider, which services or benefits are consistent with this subchapter, and any bulletins and public notices that may be issued in accordance with this subchapter as a supplement to this subchapter.

“Schedule” means the number of times a test, screen or other service must be covered or benefits provided therefor in a specified period.

11:22-2.3 Provision of a health wellness promotion program

(a) Every health benefits plan issued by a carrier shall provide benefits for a health wellness promotion program, which shall include, at a minimum, the following tests and services:

1. For all persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level;
2. For all persons 35 years of age or older, a glaucoma eye test every five years;

3. For all persons 40 years of age or older, an annual stool examination for presence of blood;

4. For all persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years;

5. For all women 20 years of age or older, a pap smear as required by N.J.S.A. 17:48-60, 17:48E-35.12, 17B:27-46.1n, or 26:2J-2.12, as applicable;

6. For all women 40 years of age or older, a mammogram examination as required by N.J.S.A. 17:48-6g, 17:48-7f, 17:48E-35.4, 17B:26-2.1e, 17B:27-46.1f, or 26:2J-4.4, as applicable;

7. For all adults, recommended immunizations according to the latest edition of the Guide for Adult Immunization, third ed., published by the American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106-1572 (www.acponline.org) incorporated herein by reference, as amended and supplemented; and

8. For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles.

(b) Notwithstanding the provisions of (a) above to the contrary, if a health care provider recommends that it would be medically appropriate for a covered person to receive a different schedule of tests and services than that provided for under this section, the carrier shall provide payment for the tests or services actually provided, within the limits of the amounts provided for in N.J.A.C. 11:22-2.4.

(c) The health benefits plan shall provide, without consideration of a separate deductible, copayment or coinsurance amount, services or benefits at least up to the dollar amounts as specified in accordance with N.J.A.C. 11:22-2.4.

(d) In the event health wellness promotion program benefits are changed or added by the Legislature, health benefit plans issued or renewed after the effective date of the change or addition shall be revised to comply with the law.

11:22-2.4 Dollar amounts to be provided for services or benefits

The Department and the Department of Health and Senior Services for HMO’s, in consultation with the Department of Treasury, shall calculate the maximum dollar amount of services or benefits to be provided no later than July 1 annually, and shall publish the results of the calculation as a public notice in the New Jersey Register and post it on the web site of each Department.

Public Notice: Mandated adjustments to benefit payments and value for services schedule.

See: 35 N.J.R. 1596(b).

Public Notice: Health Wellness Promotion Act.

See: 36 N.J.R. 2090(a).

Public Notice: Health Wellness Promotion Act.

See: 37 N.J.R. 915(b).

SUBCHAPTER 3. ELECTRONIC RECEIPT AND TRANSMISSION OF HEALTH CARE CLAIMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and P.L. 1999, c.154—The Health Information Electronic Data Interchange Technology Act (“HINT”).

Source and Effective Date

R.2001 d.364, effective October 1, 2001.

See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).

11:22-3.1 Purpose and scope

(a) Pursuant to N.J.S.A. 17B:30-23 et seq., P.L. 1999, c.154 (the Health Information Electronic Data Interchange Technology Act (“HINT” or “the Act”)), the purpose of this subchapter is to establish timetables for the introduction and implementation of systems for the electronic receipt and transmission of health care claim information, including, but not limited to, eligibility, premium payments, reports of injury, claim status, referral requests, authorization for referral, enrollment, disenrollment, and other health care claims transactions in accordance with the standards developed by the United States Department of Health and Human Services (hereinafter referred to as “DHHS”) pursuant to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (“HIPAA”) for the electronic administration of health care benefits.

(b) In accordance with N.J.S.A. 17B:30-23b, this subchapter also establishes one set of standard health care enrollment and claim forms in paper and electronic formats to be used by all health care benefit payers referred to in (d) below.

(c) Pursuant to N.J.S.A. 45:1-10.1 and 26:2H-12.12, this subchapter also establishes rules requiring health care professionals, institutions and facilities to file claims on behalf of their patients when seeking payment or reimbursement of health care claims.

(d) The subchapter applies to all hospital service corporations; medical service corporations; health services corporations; health insurers issuing individual policies of insurance; health insurers issuing group policies of insurance; health maintenance organizations; dental service corporations; dental plan organizations; and prepaid prescription service organizations; as well as any subsidiary or agent of any such entity, company or organization that may process health benefit information on behalf of a payer.

11:22-3.2 Definitions

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

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

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

“Clearinghouse” or “healthcare clearinghouse” means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and “value-added” networks and switches, that does either of the following functions:

1. Converts or facilitates the conversion of health information, that is received from another entity in a nonstandard Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, (HIPAA) format or containing nonstandard data content, into standard HIPAA data elements or a standard HIPAA transaction; or
2. Receives a standard HIPAA transaction from another entity and converts or facilitates the conversion of health information into nonstandard format or nonstandard data content for the receiving entity.

“Commissioner” means the Commissioner of the Department of Banking and Insurance.

“Covered person” means a person on whose behalf a payer has an obligation to pay benefits for health care services pursuant to a plan, policy, contract, certificate, or any other document.

“Covered service or supply” means a health care service or supply provided to a covered person under a health benefits or dental plan for which the payer is obligated to pay benefits or provide services or supplies subject to any applicable deductible, coinsurance or co-payment.

“Health benefit payer” or “payer” means those entities identified in N.J.A.C. 11:22-3.1(d) that are subject to the provisions of this chapter.

“Health care provider” or “provider” means an individual or entity which, acting within the scope of its licensure or certification, provides a covered service or supply defined by the health benefits or dental plan. Health care provider includes, but is not limited to, a physician, dentist or other

The following is an itemized description of the questions appearing on the new form. Thoroughly complete the Billing Dentist Section to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries.

1. Dentist's pretreatment estimate or statement of actual services and identification of specialty: Complete appropriate box to expedite processing and decrease chance of error. Indicate dentist's specialty by using the following abbreviations: END (Endodontist); OPY (Oral Pathologist); ORT (Orthodontist); OSY (Oral Surgeon); PDT (Periodontist); PED (Pedodontist); PHD (Public Health Dentist) and PST (Prosthodontist).
 2. Medicaid Claim, EPSDT, prior authorization number: Check for government-funded benefit programs.
 - 3-7. Carrier name, address, city, state, zip code: Carrier information where the claim is to be sent.
 - 8-11, 16. Patient name address, city, state, and zip code: Include the patient's legal name.
 12. Patient date of birth: Necessary to determine eligibility.
 13. Patient ID number: Used by dental office to identify patient. Not required to process claim.
 14. Sex: Necessary for identification purposes and for statistical analysis.
 15. Patient phone number: Necessary if questions arise that require immediate attention.
 17. Relationship to subscriber/employee: Relationship between the insured person and the patient may affect the patient's eligibility, as well as level of benefits available.
 18. Employer/School name and address: Eligibility of the dependent patient may be affected if the patient is over a certain age and is still a full-time student. This information may be necessary for coordination of benefits (COB).
 19. Subscriber/Employee ID # or Social Security number: This information refers to the insured person and is not necessarily the patient. The Social Security number (SSN) is commonly used for computer and manual processing of claims.
 20. Employer name: Self explanatory.
 21. Group number: Refers to the master contract policy number assigned to the employer group.
 - 22-30. Subscriber/Employee information: Refers to the insured person; and is not necessarily the patient.
 31. Is patient covered by another dental plan: Necessary to determine multiple coverage and COB.
 32. Policy #: Refers to master contract policy number assigned to the employer group.
 - 33-35. Other subscriber's information: Refers to employee with policy number in box #32.
 36. Plan/Program name: Necessary to identify national programs such as TRICARE.
 37. Employer/School: Refers to person in box #33. Necessary for eligibility requirements and COB.
 38. Subscriber/Employer status: Refers to person in box #22. May be necessary for eligibility and COB.
 39. Patient signature block: The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
 40. Employer/School: Refers to person in box #22. May be necessary for COB. Not required by all carriers.
 41. Employee/subscriber block: Necessary when the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
 - 42-43,46,50-52. Information for Billing Dentist, or Dental Entity: The individual dentist's name or the name of the group practice/corporation responsible for billing and other pertinent information. This may differ from the actual treating dentist's name. This is the information that should appear on any payments or correspondence that will be remitted to the billing dentist.
 44. Provider ID #: Necessary when carriers assign unique numbers to providers that differ from the Social Security number or the tax payer identification number (T.I.N).
 45. Dentist's Social Security number or T.I.N.: Refers to dentist or dental entity in box #42. The Internal Revenue Service requires that either the Social Security or T.I.N. of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated or the entity T.I.N. when the billing entity is a group practice or clinic.
 47. Dentist's license number: Refers to the license number of the billing dentist. This may differ from that of the treating dentist which appears in the Dentist's signature block (62).
 48. First visit date current series: Necessary to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
 49. Place of treatment: Necessary to determine if medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
 53. Radiographs or models enclosed: Complete when diagnostic materials are submitted.
 54. Is treatment for orthodontics? Necessary to determine the prorated benefit.
 55. If prosthesis is for a crown, bridge or denture, is this initial placement? Determines eligibility and liability.
 56. Is treatment result of occupational illness or injury? Refers to possible application of Worker's Compensation, which would alter coverage available and carrier involved.
 57. Is treatment result of auto accident? Necessary to determine reimbursement in no-fault automobile accident cases. Indicates whether another party's insurance may be responsible. Important for COB.
 58. Diagnosis Code Index: When reporting the diagnoses for treatment, refer to the ADA's SNODENT diagnostic codes (available in the year 2000). Record the 5-digit diagnoses code(s) in spaces 1-8, as necessary. The submitter should record the 5-digit diagnosis codes on line 1 through 8. In box 59, the numbers 1-8 would be entered under the diagnosis index # column.
 59. Examination and treatment plan: Use the American Dental Association's *Current Dental Terminology (CDT-3)* for appropriate procedure codes. If a procedure is performed multiple times, record the procedure code once and the frequency in the quantity (Qty) column. When completing the diagnosis index # column, enter the index # (1-8) for as many diagnoses as necessary for each procedure code. When a patient has more than one diagnoses per procedure, separate index number with comma.
 60. Identify all missing teeth with "x".
 61. Remarks for unusual services: Use to indicate any information that you feel may be helpful in determining the benefits for the treatment.
 62. Dentist's signature block: The treating dentist's signature and license number. Dentists should be aware that they may have ethical and legal obligations to refund fees for services that are paid in advance but not completed.
 - 63-66. Address where treatment was performed: Necessary if the treatment was performed at a different location than indicated in boxes #46,50-52. For administrative use only: Area where carrier calculates benefits.
- Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.

New Rule, R.2001 d.364, effective October 1, 2001.
 See: 33 N.J.R. 750(a), 33 N.J.R. 3461(a).
 Administrative correction.
 See: 39 N.J.R. 1739(a).

SUBCHAPTER 4. ORGANIZED DELIVERY SYSTEMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e and 17:48H-1 et seq.

Source and Effective Date

R.2002 d.336, effective October 21, 2002.
 See: 34 N.J.R. 20(a), 34 N.J.R. 3607(a).

11:22-4.1 Purpose and scope

(a) This subchapter sets forth the filing and requirements for an entity to be licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.

(b) This subchapter applies to any entity seeking to become licensed as an organized delivery system pursuant to N.J.S.A. 17:48H-1 et seq.; or an existing organized delivery system required to obtain a license to operate pursuant to N.J.S.A. 17:48H-11. A non-exhaustive list of examples of entities and arrangements that are subject to these rules is set forth in Exhibit B in the Appendix to this subchapter, incorporated herein by reference.

11:22-4.2 Definitions

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

“Affiliate” means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the organized delivery system.

“Capitation” means a fixed per member, per month, payment or percentage of premium payment for which the provider assumes the risk for the cost of contracted services without regard to the type, value or frequency of the services provided.

“Carrier” means an insurer authorized to transact the business of health insurance as defined at N.J.S.A. 17B:17-4, a hospital service corporation authorized to transact business in accordance with N.J.S.A. 17:48-1 et seq., a medical service corporation authorized to transact business in accordance with N.J.S.A. 17:48A-1 et seq., a health service corporation authorized to transact business in accordance with N.J.S.A. 17:48E-1 et seq. or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J-1 et seq.

“Certified organized delivery system” means an organized delivery system that is compensated on a basis which does not entail the assumption of more than de minimis financial

risk by the organized delivery system and that is certified by the DHSS in accordance with N.J.S.A. 17:48H-1 et seq.

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

“Comprehensive health care services” means the basic benefits provided under a health benefits plan, including medical and surgical services provided by licensed health care providers who may include, but are not limited to, family physicians, internists, cardiologists, psychiatrists, rheumatologists, dermatologists, orthopedists, obstetricians, gynecologists, neurologists, endocrinologists, radiologists, nephrologists, emergency services physicians, ophthalmologists, pediatricians, pathologists, general surgeons, osteopathic physicians, physical therapists and chiropractors. Basic benefits may also include inpatient or outpatient services rendered at a licensed hospital, covered services performed at an ambulatory surgical facility and ambulance services.

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

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

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

“Financial risk” means exposure to financial loss that is attributable to the liability of an organized delivery system for the payment of claims or other losses arising from covered benefits for treatment or health care services other than those performed directly by the person or organized delivery system liable for payment, including a loss sharing arrangement. A payment method wherein a provider accepts reimbursement in the form of a capitation payment for which it undertakes to provide health care services on a prepayment basis shall not per se be considered financial risk. A financial risk shall exist if, under an agreement between the organized delivery system and the carrier, the financial obligations of the organized delivery system for payment of benefits or for providing treatment or health care services does or potentially may exceed any payments that may be received from the carrier. Financial obligation shall include the attendant administrative costs related to providing the treatment or services.

“Health benefits plan” means a benefits plan which pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier. Health benefits plan includes, but is not limited to, Medicare supplement coverage and risk contracts to the extent not otherwise prohibited by Federal law. For the purposes of this subchapter, health benefits plan shall not include the following plans, policies or contracts: accident

only, credit, disability, long-term care, CHAMPUS supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance,

personal injury protection insurance issued pursuant to N.J.S.A. 39:6A-1 et seq. or hospital confinement indemnity coverage.

EXHIBIT C

Organized Delivery System

Request for Withdrawal of Funds from Segregated Account

Name of Organized Delivery System: _____

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

Name _____

Title _____

Address _____

Telephone Number _____

Fax Number _____

Amount of proposed withdrawal: _____

The proposed date of withdrawal: _____

Form of payment (cash or other assets): _____

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

For the quarter immediately preceding:

Total Assets in Segregated Account at end of quarter: _____

Net Worth of Segregated Account at end of quarter: _____

Required Net Worth at end of quarter: _____

For the quarter following the withdrawal:

Projected assets in Segregated Account at end of quarter: _____

Projected Net Worth of Segregated Account at end of quarter: _____

Projected required Net Worth at end of quarter: _____

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

Signature and certification:

SIGNATURE

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

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

(Signature of Officer)

(Title)

CERTIFICATION

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

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

(Signature) _____

(Type or print name beneath) _____

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

Authority

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

Source and Effective Date

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

izations and health maintenance organizations that deliver or issue for delivery health benefit plans, prescription drug plans or dental plans in this State.

Amended by R.2006 d.189, effective May 15, 2006.
See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

In (a), inserted “, prescription drug plans and dental plans” two times; and in (b), inserted “dental service corporations, dental plan organizations, prepaid prescription service organizations” and “, prescription drug plans or dental plans”.

11:22-5.1 Purpose and scope

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

(b) This subchapter applies to all insurance companies, health service corporations, medical service corporations, hospital service corporations, dental service corporations, dental plan organizations, prepaid prescription service organ-

11:22-5.2 Definitions

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

“Brand name drug” means a prescription drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right.

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

organization, prepaid prescription service organization or health maintenance organization authorized to issue health benefit plans, dental plans or prescription drug plans in this State.

“Formulary” means a list of prescription drugs that are preferred for use in a health benefit plan or prescription drug plan through lower cost sharing (for example, co-payment, coinsurance, deductible or out of pocket limits) or other financial incentives (for example, quantity limits or inclusion or exclusion from accumulation toward the out-of-pocket limit). A formulary may have multiple tiers. A plan that provides benefits for all brand name drugs at one level of cost sharing and for all generic drugs at another level of cost sharing is not considered a formulary for purposes of this subchapter.

“Generic drug” means any prescription drug which is not a brand name drug.

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

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

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

2. “Health benefit plan” shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of the plan:

- i. Limited scope vision benefits;
- ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

iii. Such other similar, limited benefits as are specified in Federal regulations.

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

- i. The benefits are provided under a separate policy, certificate or contract of insurance;
- ii. There is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefit plan maintained by the same plan sponsor; and
- iii. Those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

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

- i. Medicare supplemental health insurance as defined at Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1));
- ii. Coverage that is supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and
- iii. Similar supplemental coverage provided to coverage under a group health plan.

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

“Network co-payment” means the specified dollar amount a covered person must pay for covered services and supplies rendered by network providers under the health benefit plan.

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

“Network out-of-pocket limit” means the annual maximum dollar amount that a covered person must pay as copayment, deductible and coinsurance for services and supplies provided by network providers in a calendar year. All amounts paid as copayment, coinsurance and deductible shall count toward the out-of-pocket maximum, and shall not be excluded because of the nature of the service rendered, the illness or condition being treated, or for any other reason. A carrier may, however, elect to exclude from the network out-of-pocket

limit the cost sharing associated with prescription drug coverage, whether provided as part of the health benefits plan or as a rider. Once the network out-of-pocket limit has been reached, the covered person has no further obligation to pay any amounts as copayment, coinsurance or deductible for services and supplies provided by network providers (other than for prescription drugs, if prescription drugs do not accumulate toward the out-of-pocket limit) for the remainder of the calendar year.

“Point of service contract” or “POS contract” means a health benefit plan issued by a health maintenance organization or health service corporation that provides covered services and supplies through a network of providers, and pays benefits for covered services and supplies provided by out-of-network providers. The term also includes dual contracts issued pursuant to N.J.A.C. 8:38-14.7, whereby a health maintenance organization contract provides network benefits and an insurance company contract provides out-of-network benefits.

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

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

Amended by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Added definitions “Brand name drug”, “Formulary” and “Generic drug”; in definition “Carrier”, inserted “dental plan organization, prepaid prescription service organization” and “, dental plans or prescription drug plans”; in definition “Health benefit plan”, deleted former 1i. and recodified existing 1ii.-1viii. as 1i.-1vii., and in 2i., deleted “dental, drug or”; in definition “Network coinsurance”, inserted “under the health benefit plan,”; in definition “Network co-payment”, inserted “under the health benefit plan”; and rewrote definition “Network out-of-pocket limit”.

11:22-5.3 Network deductible

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

1. The contract or policy contains an individual network out-of-pocket limit that is no greater than \$7,500, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit;

2. The individual network deductible is no greater than \$2,500;
3. The individual network deductible is not applied to preventive care; and
4. The contract contains a family network deductible no greater than two times the individual network deductible.

Amended by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Inserted “providing hospital and medical coverage” in (a); and substituted “\$7,500” for “\$5,000” in (a)1.

11:22-5.4 Network coinsurance

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

1. The contract contains an individual network out-of-pocket limit that is no greater than \$7,500, and a family network out-of-pocket limit that is no greater than two times the individual network out-of-pocket limit;
 - i. If a carrier offers a contract with an individual network out-of-pocket limit in excess of \$3,000, it shall also offer a contract with an individual network out-of-pocket limit of \$2,500 or less.
2. The network coinsurance level, and the out-of-network coinsurance level (if any), is 50 percent or less;
3. The network coinsurance obligation of the covered person is computed by applying the coinsurance percentage to the contractual fee schedule of the provider, not to the billed charges of the provider; and
4. Network coinsurance cannot be applied to preventive care.

Amended by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Inserted “providing hospital and medical coverage” in (a); and substituted “\$7,500” for “\$5,000” in (a)1.

11:22-5.5 Aggregate dollar lifetime benefits maximums

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

(b) Aggregate dollar lifetime benefits maximums for out-of-network services and supplies are permitted in a POS contract issued by a health maintenance organization or a

health service corporation, or in a SCA policy issued by an insurance company, only if such maximums are in the amount of \$5 million or greater and are imposed on a per-plan per-carrier basis.

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

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

1. The following services and supplies may be covered only when provided by a network provider, and are not required to be covered when provided by an out-of-network provider:

- i. Health club membership;
- ii. Prescription drugs, other than insulin and oral agents for controlling blood sugar as mandated by N.J.S.A. 17:48-6n, 17:48A-7l, 17:48E-35.11, 17B:26-2.11, 17B:27-46.1m and 26:2J-4.11, and medications to treat infertility as mandated by N.J.S.A. 17:48-6x, 17:48A-7w, 17:48E-35.22, 17B:27-46.1x and 26:2J-4.23;
- iii. Routine dental examinations;
- iv. Routine eye care and appliances;
- v. Routine foot care;
- vi. Routine hearing care and appliances;
- vii. Smoking cessation programs; and
- viii. Travel companion benefits.

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

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

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

(c) Carriers shall not calculate benefits for services provided by out-of-network providers by using negotiated fees agreed to by network providers.

Amended by R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Added (c).

11:22-5.7 Prescription drug benefits

(a) Health benefit plans and stand-alone prescription drug plans that provide benefits for prescription drugs listed on a formulary may provide higher benefits for formulary drugs than for nonformulary drugs, provided:

1. The benefit for all tiers of formulary and nonformulary drug coverage shall result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the drug, after application of any deductibles, for prescription drugs provided by network providers. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent.

2. If a health benefit plan has a separate deductible for prescription drugs, or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for all tiers of formulary drugs and \$250.00 per year for all tiers of nonformulary drugs; and

3. If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for formulary and nonformulary drugs.

(b) Health benefit plans and stand-alone prescription drug plans that provide prescription drug benefits through use of a formulary, shall meet the following criteria:

1. The formulary shall be developed by a pharmacy and therapeutics committee composed of health care professionals with recognized knowledge and expertise in clinically appropriate prescribing, dispensing and monitoring of outpatient drugs or drug use review, evaluation and intervention. The membership of the committee shall consist of at least two-thirds licensed and actively practicing physicians and pharmacists, and shall consist of at least one pharmacist. If the carrier contracts with a third party to develop the formulary, the carrier shall be responsible for guaranteeing that the third party complies with all requirements relating to formularies as set forth in this subsection.

2. All drugs in a formulary shall be approved under the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §§301 et seq.

3. The most preferred tier of a formulary, that is, the tier with the lowest cost sharing, shall include more than one drug used to treat each covered disease state where more than one drug is available.

4. A drug may be excluded from the most preferred tier of a formulary only if, based on the compendia listed in (c)6 below, it does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness or clinical outcome of treatment for the specific condition for which the drug is intended over other drugs included in the formulary, and there is a written explanation of the basis for the exclusion that is available to providers and covered persons upon request.

5. Each health benefit plan utilizing selective contracting arrangements that provides benefits for formulary drugs shall also provide benefits for nonformulary drugs. There shall be no difference in benefit level between formulary and nonformulary drugs obtained from out-of-network providers.

6. The carrier shall establish an approval process to enable health care providers and covered persons to obtain coverage of nonformulary drugs at the same level as formulary drugs where the prescribing health care provider certifies the medical necessity of the drug.

i. A nonformulary drug shall be considered medically necessary if:

(1) It is approved under the Federal Food, Drug and Cosmetic Act, 21 U.S.C. §§301 et seq.; or its use is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: The American Hospital Formulary Service Drug Information or the United States Pharmacopoeia – Drug Information, or it is recommended by a clinical study or review article in a major peer-reviewed professional journal; and

(2) The prescribing health care provider states that all formulary drugs used to treat each disease state have been ineffective in the treatment of the covered person's disease or condition, or all such drugs have caused or are reasonably expected to cause adverse or harmful reactions in the covered person.

ii. The approval process for nonformulary drugs shall provide that the carrier respond to the prescribing health care provider by telephone or other telecommunication device within one business day of a request for prior authorization. Failure to respond within one business day shall be deemed an approval of the request. Initial denials shall also be provided to the prescribing health care provider and covered person in writing within five business days of receipt of the request for approval of a nonformulary drug, and shall include the clinical reason for the denial. Such denials are appealable to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c. 192, §11.

7. The carrier shall publish and distribute, at least quarterly, either its current formulary or a list of

nonformularies to network providers. Such list shall clearly indicate whether the drugs included are formulary or nonformulary. Alternatively, the carrier may annually distribute new formularies or a list of nonformularies, and quarterly updates, to network providers. The current formulary or list of nonformulary drugs shall be provided by the carrier to covered persons upon request.

8. The contract and evidence of coverage form shall disclose the existence of the drug formulary, describe the approval process to obtain coverage of nonformulary drugs as formulary drugs and describe the process to appeal a denial of a request for approval of a nonformulary drug, including the right to appeal to the Independent Health Care Appeals Program in the Department of Health and Senior Services pursuant to P.L. 1997, c.192, §11. The contract and evidence of coverage form shall state that a copy of the formulary will be provided by the carrier to a covered person upon request.

(c) Health benefit plans and stand-alone prescription drug plans may provide higher benefits for generic drugs than for brand name drugs provided:

1. The benefit for both generic and brand name drugs must result in a cost to the covered person of no more than 50 percent of the plan's contracted cost of the medication for prescription drugs obtained from network providers. A deductible, as described in 2. below, does not need to be considered in calculating the covered person's cost. For prescription drugs provided by out-of-network providers, coinsurance shall not exceed 50 percent.

2. If a health benefit plan has a separate deductible for prescription drugs or a stand-alone prescription drug plan has a deductible, such deductible shall not exceed \$250.00 per calendar year for generic drugs and \$250.00 per calendar year for non-generic drugs.

3. If a health benefit plan or a stand-alone prescription drug plan has a benefit maximum for prescription drugs, the maximum shall be the same for generic and brand name drugs.

New Rule, R.2006 d.189, effective May 15, 2006.

See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

Former N.J.A.C. 11:22-5.7, Effect on previously-approved forms, recodified to N.J.A.C. 11:22-5.9.

11:22-5.8 Dental benefits

(a) The following standards apply to health benefit plans and stand-alone dental plans that provide benefits for dental services only when rendered by network providers, and plans that provide benefits for dental services rendered by both network and out-of-network providers:

1. For services rendered by network providers, the plan shall provide benefits that result in a cost to the covered person of no more than 75 percent of the plan's contracted cost of the covered services, after application of any deductibles; and

2. For services rendered by out-of-network providers, coinsurance shall not exceed 75 percent.

New Rule, R.2006 d.189, effective May 15, 2006.
See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).

11:22-5.9 Effect on previously-approved forms

Any form that was previously filed with and approved by the Commissioner, but does not meet the requirements of this subchapter, shall be deemed withdrawn as of July 1, 2006 and may not be made available for new issue or for renewal on or after that date.

Recodified from N.J.A.C. 11:22-5.7 and amended by R.2006 d.189, effective May 15, 2006.
See: 37 N.J.R. 4510(a), 38 N.J.R. 2159(a).
Rewrote the section.

SUBCHAPTER 6. EXCLUSIONS AND PREAUTHORIZATION REQUIREMENTS

Authority

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

Source and Effective Date

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

11:22-6.1 Purpose and scope

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

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

11:22-6.2 Definitions

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

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

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

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

“Health benefits plan” means any hospital and medical expense insurance policy or certificate; health, hospital, or

medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier. For purposes of this subchapter, “health benefits plan” shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefit plans shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefit plans shall not include hospital confinement indemnity coverage if: the benefits are provided under a separate policy, certificate or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor; and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance as defined under section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

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

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

11:22-6.3 War exclusions

(a) The Department shall permit war risk exclusions in health benefit plans only if they consist of military exclusions, noncombatant exclusions and/or civilian

exclusions. Military, noncombatant and civilian exclusions shall be no more restrictive than the following:

Source and Effective Date

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

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

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

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

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

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

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

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

11:22-6.4 Requirements for preauthorization provisions

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

11:22-6.5 Effect on previously filed forms

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

11:22-7.1 Purpose and scope

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

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

11:22-7.2 Definitions

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

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

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

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

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

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

SUBCHAPTER 7. CARRIER/PROVIDER JOINT
NEGOTIATION AGREEMENTS

Authority

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