"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 calcula-

tion as a public notice in the New Jersey Register and post it on the web site of each Department.

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.

"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(c) 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 health care professional licensed pursuant to Title 45 of the Revised Statutes; a hospital and other health care facility licensed pursuant to Title 26 of the Revised Statutes; and/or a purveyor of prescription, pharmaceutical products or durable medical goods or equipment.

"Health care transaction" or "transaction," for purposes of this subchapter only, means the exchange of information between two or more parties to carry out the financial and administrative activities related to coverage under a health benefits or dental plan, including, but not limited to, health claims and equivalent encounter information, health care payment and admittance advice, health claims status, enrollment and disenrollment in a health plan, eligibility for a health plan, health or dental plan premium payments, first report of injury, deferral certification and authorization and health care attachments.