

(d) Every member shall be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period unless the member has been granted a full exemption from assessments for the preceding two-year calculation period by the Board in accordance with N.J.A.C. 11:20-9.

1. The IHC Program Board shall provide a preliminary notice to its members in writing, on or about May 1 of the year following every two-year calculation period, of the total reimbursable net paid losses for the preceding two-year calculation period and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for the preceding two-year calculation period.

2. On or about September 1 of the year following every two-year calculation period, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed against the member for its portion of the total reimbursable net paid losses for the preceding two-year calculation period.

3. The IHC Program Board may, as necessary, make reconciliations from the preliminary notice of the assessment for reimbursable net paid losses which may include adjustments in market share and adjustments for deferrals granted.

4. Upon the resolution of all outstanding matters including audits of reimbursable losses and appeals filed pursuant thereto, the IHC Program Board shall notify each member of the final reconciliation of the assessment for reimbursable net paid losses for the appropriate two-year calculation period by invoice stating the dollar amount then due or credit, if any, against future assessments. As a result of the final reconciliation, any monies determined to be owed to or by the Board shall be calculated without provision for interest.

(e) Assessments amounts are due and payable upon receipt by a member of the invoice for the assessment. Payment shall be by bank draft made payable to the Treasurer—State of New Jersey, IHC Program, at the address set forth in N.J.A.C. 11:20-2.1(h).

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent of the assessment amount not timely paid per month, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment, for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating to or involving an assessment or any other error resulting in non-payment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20-11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Executive Director shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for the two-year calculation period. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for that two-year calculation period, until such available funds have been paid out, or a member's reimbursable net paid losses for that two-year calculation period have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request, including any interest penalty paid by a member pursuant thereto, shall not be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period, until such time as the dispute has been settled against the disputing member, or the deferral denied, except that any portion of an assessment

not in dispute or subject to a deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses for the preceding two-year calculation period year in accordance with (g) above, along with any applicable interest penalty amounts paid or interest accrued while held in escrow by the Board.

2. Upon receipt of notice that amounts of assessment disputed or subject to deferral wherein the dispute is settled in favor of the disputing member, or a deferral is granted, the Executive Director shall calculate the proportionate amount of interest, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board and provide notice to the carrier of the principal amount and interest amount. The calculated amount shall be returned to the member with interest within 30 days from the date the interest has been calculated.

New Rule, R.1994 d.165, effective March 1, 1994.
See: 26 N.J.R. 1200(a), 26 N.J.R. 1507(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.

SUBCHAPTER 3. STANDARD BENEFIT LEVELS AND POLICY FORMS

11:20-3.1 Benefits provided

(a) The standard individual health benefits plan established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, Exhibit A;
2. Plan B, "Individual Health Benefits Plan," Exhibit B;
3. Plan C, "Individual Health Benefits Plan C," Exhibit C;
4. Plan D, "Individual Health Benefits Plan D," Exhibit D;
5. Plan E, "Individual Health Benefits Plan E," Exhibit E;
6. HMO Plan, "Health Maintenance Organization Benefits Plan," Exhibit F; and
7. Plan A/50, "Basic Health Benefits Plan A/50," Exhibit U.

(b) In accordance with N.J.A.C. 11:20-1.3, members that offer individual health benefits plans in this State shall offer standard health benefits Plans A/50, B, C, and D as set forth in Exhibits U, and B through D, respectively, with variable text as specified on the Explanation of Brackets, Exhibit T, in the Appendix.

1. Members offering Plan D shall offer the following annual deductible options to the policyholder for each plan:

- i. \$500.00 per individual and \$1,000 per family unit;
- ii. \$1,000 per individual and \$2,000 per family unit;

2. Members offering Plans A/50, B and C shall offer the following annual deductible options to the policyholder for each plan:

- i. \$1,000 per individual and \$2,000 per family unit; and
- ii. \$2,500 per individual and \$5,000 per family unit.

3. Members offering Plans C and D may offer those plans, on a guaranteed issue basis, with either or both of the following annual deductible options to the policyholder in addition to those deductible options listed in (b)1 and 2 above:

- i. \$1,500, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$3,000, or effective January 1, 1999, the lowest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit;
- ii. \$2,250, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to § 220 of the Internal Revenue Code per individual or in the case of a family unit, \$4,500, or effective January 1, 1999, the highest inflation-adjusted amount for the calendar year in which the coverage is issued or renewed, determined by the Federal Internal Revenue Service pursuant to §220 of the Internal Revenue Code per family unit.

4. Members offering Plan A/50 shall offer the following annual deductible options to the policyholder for each plan:

- i. \$5,000 per individual and \$10,000 per family unit; and
- ii. \$10,000 per individual and \$20,000 per family unit.

(c) Members which are Federally-qualified HMOs may offer the HMO Plan, as set forth in Exhibit F of the Appendix, in lieu of Plans A/50, B, C, and D in (a) above. All HMO members offering the HMO Plan shall offer the following arrangements: \$150.00 hospital inpatient copay, \$150.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 separate emergency room copay, \$25.00 maternity copay, and \$15.00 for all other copays. All HMO members choosing to offer optional health benefits plans may offer one or both of the following copayment options, provided that all options marketed shall be offered to each applicant;

1. \$250.00 hospital inpatient copay, \$200.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$20.00 for all other copays; and/or

2. \$100.00 hospital inpatient copay, \$100.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$10.00 for all other copays.

3. \$300.00 hospital patient copay, \$300.00 mental/nervous and substance abuse hospital inpatient copay and alcoholism hospital inpatient copay, \$50.00 emergency room copay, \$25.00 maternity copay, and \$30.00 for all other copays.

(d) Each of the standard health benefits plans, except Plan A/50 and the deductible options listed in (b)3 above, may be offered through or in conjunction with a managed care network, and the standard plans may be offered as a PPO or POS plan by a carrier that is exempt from the requirements of P.L. 1993, c.162, § 22, pursuant to N.J.A.C. 11:4-37.1(b), but which is permitted to enter into agreements with participating providers pursuant to any statute. These plans should be subject to the following:

1. All of the requirements of N.J.A.C. 11:4-37.3(b)6;

2. The coinsured charge limit specified for the standard health benefits plan being offered through or in conjunction with a managed care network, as set forth in Exhibits B through D in the Appendix, shall be the maximum amount of covered charges a covered person must incur for the in-network and out-network benefits combined before benefits are paid by the carrier at 100 percent;

3. The HMO Plan copayment levels of \$10.00, \$15.00, \$20.00 and \$30.00 may be substituted for deductibles applicable to one or more of the in-network benefits; and

4. The out-network benefit level shall be the coinsurance level of the standard plan. Plan B offered through or in conjunction with a managed care network shall have an out-network coinsurance amount of 60 percent, Plan C shall have an out-network level of 70 percent, and Plan D shall have an out-network level of 80 percent.

(e) In paying benefits for covered services provided by health care providers not subject to capitated or negotiated

fee arrangements, carriers shall pay covered charges for medical services, based on a reasonable and customary basis or actual charges, and, for hospital services, based on actual charges. Reasonable and customary means the 80th percentile of the Prevailing Healthcare Charges System (PHCS) profile for New Jersey, or such other state where services or supplies are provided, for various medical services and supplies, published and available to carriers from the Health Insurance Association of America, 6th Floor, East Tower, Columbia Square, 555 13th Street, NW, Washington, DC 20004-1109. Carriers shall update their databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

Amended by R.1995 d.531, effective October 2, 1995.

See: 27 N.J.R. 1127(a), 27 N.J.R. 3793(b).

Amended by R.1997 d.3, effective December 5, 1996.

See: 28 N.J.R. 4856(a), 29 N.J.R. 138(a).

Inserted new (b)2; recodified former (b)2 as (b)3; and, in (c), inserted reference to (b)2 deductible options.

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).

Substituted Plan B for Plan A as the "The Basic Health Benefits Plan" and amended deductible and copayment amounts.

Amended by R.1998 d.26, effective January 5, 1998.

See: 29 N.J.R. 1089(a), 30 N.J.R. 237(a).

Inserted (d)6.

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.

11:20-3.2 Policy forms

(a) For standard health benefits plans, members shall use the standard policy forms set forth in the Appendix to this subchapter as Exhibits A through F and U, as may be amended by the Board.

(b) A member choosing to offer a standard health benefits plan through or in conjunction with a managed care network in accordance with N.J.A.C. 11:20-3.1(d) shall use the appropriate standard language set forth in the Appendix to this subchapter as alternate text in Exhibits B, C and D as described in the Explanation of Brackets, Exhibit T, in conjunction with the standard policy forms set forth as Exhibits B through D.

(c) Before marketing, issuing or renewing any of the standard policy forms, a member shall file with the Board, the Certification Form set forth in the Appendix to this subchapter as Exhibit Q. Affiliated Carriers must file separate Certification Forms. A new Certification Form must be filed annually on or before March 1.

(d) Carriers that submit an Exhibit Q Certification Form may issue and make effective individual health benefits plans upon filing such forms with the Board, and may continue to do so until such time as the filing is disapproved in writing by the Board, following an opportunity for a hearing pursuant to the procedures set forth in N.J.A.C. 11:20-20.2. The Board may disapprove an Exhibit Q Certification filing if the filing is inaccurate or incomplete.

Repeal and New Rule, R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

Sec: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

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

Sec: 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).

Sec: 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.

11:20-3.3 Compliance and variability rider

(a) Notwithstanding the requirements of N.J.A.C. 11:20-3.2, 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 S 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) Notwithstanding the requirements of N.J.A.C. 11:20-3.2, 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, B, C, D, E and U of the Appendix to this Chapter, as described in the Explanation of Brackets, Exhibit T, through the use of the Compliance and Variability Rider as set forth as Exhibit S of the Appendix.

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

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

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

Sec: 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.

SUBCHAPTER 4. STANDARD APPLICATION FORM

11:20-4.1 Standard application form

All members offering standard health benefits plans with an effective date on or after August 1, 1993, shall use the standard application form approved by the Board and specified in Exhibit G with the variable text explained on the Explanation of Brackets, Exhibit T of the Appendix to this chapter.

Amended by R.1995 d.51, effective December 23, 1994 (operative January 1, 1995).

Sec: 26 N.J.R. 4884(a), 27 N.J.R. 565(a).

Administrative Correction.

Sec: 27 N.J.R. 1424(a).

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

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

Rewrote the section.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:20-5.1 Standard claim form

All members offering health benefits plans or other health insurance policies to individuals, to the extent that the member uses claims forms in its transaction of business (rather than an electronic billing system), shall require as a condition of payment, the standard claims form approved by the Board and set forth as Exhibit H in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions set forth in Exhibit H shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-92 set forth as Exhibit I shall be the standard claim form for all hospital inpatient services.

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

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

Rewrote the section.

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 2b(1) and 3 of the Act (N.J.S.A. 17B:-27A-3b(1) and 17B:27A-4).

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 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 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;

2. Premium rates and any factors used in the calculation of the premium rates. The premium rates may be for a period of effective dates not to exceed 12 months from the initial effective date, and may be developed on different rate tiers for: individuals; husband/wife; adult/child(ren); family; and, at the option of the carrier, child(ren) only coverage, provided that all proposed rates applicable in the State have been filed with the Board before being used to quote new business or renewals;

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

- i. The rates being submitted;

- ii. All information used in the development of the rates;

- iii. The anticipated loss experience and the assumptions used in developing such anticipated loss experience, including historical experience, trend assumptions, plan relativity assumptions, and any other factors used in developing the anticipated loss experience; and

- iv. The administrative expense, premium tax and commission payment assumptions, and other margins;

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; and

If Your Spouse loses coverage due to a divorce, the Spouse may apply for his or her own individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

If Your Spouse applies for the new coverage within 31 days of the divorce and meets Our Underwriting Requirements, the effective date of the new coverage shall be the day following the date the Spouse's coverage under this Contract ended. Any Pre-existing Condition limitation or other limitation not satisfied by the Spouse under this Contract will apply under the new coverage to the extent it remains unsatisfied.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying Premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement made by You, shall be used in contesting the validity of Your coverage or in denying a claim for benefits after such coverage has been in force for two years during Your lifetime.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after You file written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to You: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in Your application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been furnished to You for attachment to this Contract.

CONTRACT INTERPRETATION

We shall administer this Contract in accordance with its terms and shall have the sole power to Determine all questions arising in connection with its administration, interpretation and application.

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent becomes eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or the Dependent is no longer a Dependent, as defined in the Contract.. Coverage ends at 12:01 a.m. on the date the first of these events occurs.

Also, Dependent coverage ends when the Contractholder's coverage ends.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

TERMINATION OF THE CONTRACT - RENEWAL PRIVILEGE

During or at End of Grace Period - Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Contract will end [when that period ends.][as of the end of the period for which premium has been paid.]

Termination by Request - If You want to replace this Contract with another Individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which Premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Anniversary Date, unless coverage is terminated on or before the Anniversary Date due to one of the following circumstances:

You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as of the end of the grace period.][Coverage will end as of the end of the period for which premium has been paid.]

You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].)

termination of eligibility if You become eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; (Coverage will end immediately.)

with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)

You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided You notify Us of the replacement within 30 days after the effective date of the new plan.)

subject to the statutory notification requirements, We cease to do business in the individual health benefits market;

subject to the statutory notification requirements, We cease offering and non-renew a particular type of Health Benefits Plan in the individual health benefits market, provided We act uniformly without regard to any Health Status-Related Factor of Members or persons who may have become eligible for coverage.

[You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]

THE CONTRACT

The entire Contract consists of:

the forms shown in the Table of Contents as of the Effective Date;

the Contractholder's application, a copy of which is attached to the Contract;

any riders, endorsements or amendments to the Contract; and

the individual applications, if any, of all Members.

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).

Amended by R.1999 d.382, effective October 8, 1999 (operative November 1, 1999).

See: 31 N.J.R. 2682(a), 31 N.J.R. 3339(a).

EXHIBIT G

APPLICATION FOR INDIVIDUAL HEALTH BENEFITS PLAN
FOR INDIVIDUALS AND FAMILIES

Eligibility Requirements

1. Eligibility requirements are determined under the Individual Health Coverage Reform Act of 1992, P.L. 1992, c.161.
2. You must be a New Jersey resident.
3. You and any family members you wish to cover must not be eligible to be covered under:
 - (a) a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan; or
 - (b) Medicare.
 (See item 5 below.)
4. You and any family members you wish to cover are not eligible for a standard individual health benefits plan if covered by another individual health benefits plan unless the other plan is being replaced by the plan being applied for with this application.
5. If the requested effective date is not completed, your effective date shall be no later than the first of the month following the month in which the completed application was dated and premium payment are received by us or our duly authorized agent. However, with respect to applications submitted during the October Open Enrollment Period by persons who are eligible for coverage under a group Health Benefits Plan, Group Health Plan, Governmental Plan, or Church Plan, or persons who wish to replace their current health benefit plan with a more comprehensive individual health benefits plan, the effective date of your coverage shall be January 1 of the following calendar year. Current coverage should not be terminated until new coverage is in effect.

INDIVIDUAL APPLICATION INSTRUCTIONS

BEFORE COMPLETING THIS APPLICATION BE SURE TO FAMILIARIZE YOURSELF WITH THE BENEFIT OPTIONS AVAILABLE. [NOTE: [CARRIER'S] PARTICIPATING PROVIDERS, INCLUDING ALL [PARTICIPATING] [NETWORK] PRIMARY CARE PHYSICIANS, ARE INDEPENDENT CONTRACTORS AND ARE NOT AGENTS OR EMPLOYEES OF [CARRIER].]

COMPLETE ALL SECTIONS IF YOU ARE:

1. [Applying] [Enrolling] as a new [insured] [enrolled] [subscriber] [member].
2. Changing dependent coverage.

COMPLETE SECTIONS 1, 2, 3, [AND] [5] AND [6] IF YOU ARE TERMINATING YOUR COVERAGE.

Section 1--Print your full name along with the name(s) of your spouse and dependent children you wish to cover, if any. Provide date of birth, sex, and social security number for each individual listed. Your social security number is for our use. The New Jersey Individual Health Coverage Program Board will not collect or use your social security number. If a dependent is a full-time college student, you **must** attach a current course schedule or tuition receipt. If a dependent is beyond age 19 or 23, as applicable, but is mentally or physically handicapped or developmentally disabled, unmarried and chiefly dependent upon the applicant or applicant's spouse for support and maintenance, a physician's statement as to the dependent's physical or mental incapacity must be provided. The add/remove blocks should be checked **only** if you wish to add or remove a dependent from the plan.

Section 2--Complete all information.

Section 3--Check box(es) indicating options for coverage, type of contract, [payment plan] and reason(s) for submitting form (i.e., new enrollment, coverage change, name change, withdrawal).

Section 4--This information is required. Please complete all information.

[Section 5--For applicants only] From the appropriate [directory] [brochure] [] choose [the location number for] a Primary Care Physician [or Health Center] [and/or Gynecologist if applicable,] [for yourself and each member of your family] [required for all members]. [If you choose a Health Center, you must choose a Primary Care Physician who services that Health Center.] [Indicate whether you are choosing [carrier's] Statewide Physician Network or Health Center.] Check the change box only if you are changing providers.

Section [5/6]--Applicant **must sign** this section and date this form or it will not be processed.

CONDITIONS OF ACCEPTANCE

On behalf of myself and the dependents listed [on the following page,] [on the reverse side,] I agree to or with the following:

1. Coverage of applicant and of the listed dependents shall depend on acceptance by [carrier] after a review of the application [and receipt of payment].
2. Applicant is applying for individual coverage for the applicant, applicant's spouse and any eligible unmarried children under nineteen (19) years of age, unmarried children who are mentally or physically incapacitated or developmentally disabled, who are chiefly dependent upon the applicant or the applicant's spouse for support and maintenance, or are unmarried children between the ages of nineteen (19) and twenty-three (23) who are full-time students at an accredited educational institution.

3. Coverage and benefits are contingent on timely payment of premiums. Coverage may be terminated as provided in the Individual [Contract] [Policy].
4. The Individual [Contract] [Policy] will determine the rights and responsibilities of [insured(s)] [enrollee(s)] [subscriber(s)] [member(s)] and will govern in the event it conflicts with any benefits comparison, summary or other description of the health benefits plan.
5. [As a condition to benefits, applicant understands and agrees that (with the exception of a medical emergency as defined in the Individual [Contract] [Policy] all services, in order to be covered by [Carrier], must be performed either by a Primary Care Physician or by the specialist, hospital or other provider as authorized by prior written referral from the Primary Care Physician [or Care Manager].]
6. [[If applicable,] Applicant agrees to make payment directly to health care providers, such copayments as are provided for in the Individual [Contract] [Policy].]
7. [Applicant understands that this coverage will remain in effect regardless of the continued availability of a particular [Health Center], Primary Care Physician or other health care provider.]
8. [Applicant acknowledges that [Carrier's] participating providers, including all participating primary care physicians, are independent contractors and are not agents or employees of [Carrier].]

Please print in ink all information requested on this application.

1. Eligible Persons to be Enrolled. (Note: Dependent children may be covered under an adult-child(ren) or family contract only while unmarried and until [they attain] age 19, or 23 if full-time students. Unmarried, handicapped dependent children can continue beyond the age limits above as long as they remain incapacitated and unmarried.*

This section must be completed in its entirety.

LAST NAME	FIRST NAME	MI	BIRTHDATE			SEX	Social Security Number
			MO	DAY	YR	M or F	
Applicant 1. <input type="radio"/> Add <input type="radio"/> Remove							__/__/__-__/__/__
Spouse 2. <input type="radio"/> Add <input type="radio"/> Remove							__/__/__-__/__/__
Child 3. <input type="radio"/> Add <input type="radio"/> Remove							__/__/__-__/__/__
Child 4. <input type="radio"/> Add <input type="radio"/> Remove							__/__/__-__/__/__
Child 5. <input type="radio"/> Add <input type="radio"/> Remove							__/__/__-__/__/__

*Attach sheet to list additional children. [Attach proof if full-time student. Totally disabled children will be covered regardless of age. Attach proof of disability.]

DEPENDENT INFORMATION

Do any of the dependents listed in #1 live at another address? Yes No

If yes, who and at what address?

 Explain the circumstances.

Type of Coverage: Check all that apply.
 _____ Group _____ Individual
 _____ Indemnity _____ HMO _____ PPO _____ Point of Service
 _____ Other (Specify) _____

Plan Information: Deductible Amount: _____
 Coinsurance: _____
 Copayment: _____

Initial Effective Date: _____ Termination Date: _____]]

COVERAGE (Please mark Coverage, Type of Contract and Type of Activity)

PLEASE ENROLL ME (AND MY DEPENDENTS) IN: (Only one plan and one deductible option may be selected)

[PLAN A/50	Deductible	\$1000 _____ \$2500 _____
		[\$5000 _____ \$10000 _____]
PLAN B [<input type="checkbox"/> Indemnity] [<input type="checkbox"/> Preferred Provider]	Deductible	\$1000 _____ \$2500 _____
PLAN C [<input type="checkbox"/> Indemnity] [<input type="checkbox"/> Point of Service] [<input type="checkbox"/> Preferred Provider]	Deductible	\$1000 _____ \$2500 _____ [per individual
\$1500 _____ \$2250 _____ per family \$3000 _____ \$4500 _____]		
PLAN D [<input type="checkbox"/> Indemnity] [<input type="checkbox"/> Point of Service] [<input type="checkbox"/> Preferred Provider]	Deductible	\$500 _____ \$1000 _____ [per individual
\$1500 _____ \$2250 _____ per family \$3000 _____ \$4500 _____]		

[HMO Plan [\$10] \$15 [\$20] [\$30] copayment.] [Well Child Care Option Yes No]]

Type of Contract: Single
 Family
 Adult & Child(ren)
 Husband/Wife
 Child(ren)]

[If you selected Plan C or Plan D with a [\$1500 per individual] [[\$2250 per individual] [\$3000 per family] [\$4500 per family] Deductible option, do you intend to participate in a Medical Savings Account?
 Yes No]

Requested Effective Date - [Must be the 1st or 15th of the month]: _____

Type of Activity:

<input type="checkbox"/> New [Subscriber]	<input type="checkbox"/> Name Change from _____ to _____
<input type="checkbox"/> Converting from existing (carrier) plan ID # _____	<input type="checkbox"/> [Change of Primary Care Physician or Gynecologist]
<input type="checkbox"/> Add/Remove Dependent Reason _____ Date of Event _____	<input type="checkbox"/> [Change of Health [Care] Center from _____ to _____]
	<input type="checkbox"/> [Change of Primary Care Physician at Health [Care] Center]
	<input type="checkbox"/> Withdrawal From Coverage Date of Event _____

SELECT THE PAYMENT PLAN YOU DESIRE

Monthly Quarterly Semi-Annually]

[PAYMENT MODE:
 Check
 Money Order
 Credit Card Type _____ No. _____ Exp. Date _____]
 Automatic Bank Draft (attach voided check)]

[' Automatic Bank Draft (attach voided check)]

[' Other _____ Amount \$ _____]]

4. OTHER HEALTH CARE COVERAGE (Note: In some situations, if you are eligible for or have other health benefits coverage, you are not eligible for this [policy] [coverage]. If you or other dependents become eligible for or become covered under other health benefits coverage, after the date of this application, you must notify us as soon as possible, however no later than the effective date of such other coverage.)

Are you employed? ' Yes ' No If yes, please give name and address of your employer.
Are you eligible for other health benefits coverage? ' Yes ' No (i.e., coverage under your employer's health benefits coverage or Medicare).
If yes, give name and policy no. of other carrier or type of coverage.
Are other dependents eligible for coverage? If yes, specify.
Do you or other dependents currently have any other health care coverage? ' Yes ' No
If yes, give name and policy/certificate no. of other carrier, initial effective date of coverage and specify those covered by the policy/certificate:
Are you replacing existing coverage? ' Yes ' No
If yes, give name and policy no. of other carrier, initial effective date of coverage, date of termination, and specify those covered by policy. If you are replacing coverage and the plan is an Individual Health Coverage (IHC) Plan or a Small Employer Health Benefits (SEH) Plan, please identify the letter of the plan being replaced. _____
Were you, or any dependent(s) to be covered, covered under a prior Group Health Plan? ' Yes ' No If "Yes", attach the Certificate of Creditable Coverage
[Have you or your dependents ever been a member of [carrier]?)
[If yes, under what name and social security no.?)
[Where? [carrier] of:]

[PRE-EXISTING CONDITIONS STATEMENT

Note: This information may ONLY be used to determine if a condition is a pre-existing condition. You CANNOT be denied coverage under a health benefits plan on the basis of accurate responses to the following questions. Carriers can only use the information to expedite the processing of claims. However, benefits, services or supplies for the treatment of a pre-existing condition may be limited for 12 months. Consult the Buyer's Guide, the carrier or your agent for information concerning the application of the pre-existing conditions limitation.

1. During the past 6 months have you, or any dependent to be covered had, or been diagnosed as having:

	Yes	No
a. Alcoholism, Drug Abuse	_____	_____
b. Arthritis	_____	_____
c. Blood Disorder	_____	_____
d. Back or Neck Disorder, Injury or Pain	_____	_____
e. Cancer or Tumors	_____	_____
f. Diabetes	_____	_____
g. Gastro or Intestinal Disorder	_____	_____
h. Heart Disorder or Condition or Chest Pain	_____	_____
i. High Blood Pressure	_____	_____
j. Kidney or Liver Disorder	_____	_____
k. Lung or Respiratory Disorder	_____	_____
l. Mental or Nervous Disorder	_____	_____

n. Does Pregnancy Exist _____
 Expected Due Date: _____

2. During the past 6 months, have you or any dependent to be covered:

- | | | |
|--|-------|-------|
| | Yes | No |
| a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above? | _____ | _____ |
| b. been advised to have treatment or surgery or testing that has not been done? | _____ | _____ |
| c. been admitted to a hospital or other health care facility as an inpatient? | _____ | _____ |
| d. taken prescribed medications? | _____ | _____ |

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question	Name	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

[5. PROVIDER SELECTION

	FULL NAME OF PRIMARY CARE PHYSICIAN AND OFFICE ID NO.	[HEALTH CENTER* (if applicable)]	[GYNECOLOGIST OFFICE NO.]	[ESTABLISHED PATIENT]	PRIMARY CARE PHYSICIAN CHANGE	[HEALTH CENTER CHANGE]
1. Applicant				o Yes o No	o	o
2. Spouse				o Yes o No	o	o
3. Child				o Yes o No	o	o
4. Child				o Yes o No	o	o
5. Child				o Yes o No	o	o]
[Statewide Physician Network o Health Center o]						

[*When selecting Health Center option, please also select a Primary Care Physician from among the Health Center doctors.]
 [NOTE: A Primary Care Physician must be selected for each adult member and a Pediatrician must be selected for each child. Women over the age of 16 must also select a GYN.]

[5.][6.] AUTHORIZATION AND CERTIFICATION

I hereby apply to [carrier] for coverage for any eligible dependents listed above and myself.

[I have been offered the opportunity to add the following coverage(s) to the New Jersey Individual Health Benefits Plan and I accept or reject, as shown below: Coverage for treatment of cancer by dose intensive chemotherapy/autologous bone marrow transplants and peripheral blood stem cell transplants pursuant to New Jersey Assembly Bill 1997, P.L. 1995, c.100. o Accept o Reject]

I understand that for the 12 months following the effective date of this [policy] [contract], benefits are not provided for health care services received for (a) conditions for which medical advice, diagnosis, care or treatment was recommended or received during the last 6 months, (b) conditions for which during the last 6 months there were symptoms which would cause a prudent person to seek medical advice, diagnosis, care, or treatment, or (c) pregnancy existing on the effective date of this [policy] [contract]. (Note: This

limitation will not apply if you are a Federally Defined Eligible Individual and may not apply if the eligible person transfers from another health benefits plan.)

[[Unless I request otherwise in writing,] I understand that by signing below when I file a claim, [carrier] may pay the health care benefits directly to the provider instead of to me.]

I agree that: (a) any physician, hospital or other provider is authorized to provide to [carrier or its assignee] information about any eligible person's medical history; and (b) any company or person having information concerning other health care coverage in force, or available to, any eligible person may give such information to [carrier or its assignee.]

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I state that: (a) I am a resident of New Jersey [and reside live or work within the [carrier] service area (if applicable)], (b) the information given on this application is complete to the best of my knowledge and belief and (c) that [carrier] will rely on this information to determine eligibility. I understand that if I omit or falsify any statement in this application [carrier] can cancel this contract [as of the original effective date][immediately].

Applicant's Signature: _____ Date Signed _____

Spouse's Signature _____ Date Signed _____

Preparer's Signature: _____ DOBI License # _____ Date Signed _____

NOTE TO ALL APPLICANTS: If we accept your application, a copy of the application will be sent to you. Attach the copy to your [contract] [policy]. It becomes part of your contract with us.

For [Carrier] [Plan] Use Only	[Effective Date]	[Billing]	[Coverage Code]	[Type]	[Pre-Ex]	[Continuous Coverage]	[Transcode]	[]

[[6][7] AGENT/PRODUCER INFORMATION

[To be supplied by Carrier, and limited in scope to information concerning the agent/broker]]

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.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).
 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).
 Amended by R.1999 d.131, effective March 25, 1999.
 See: 31 N.J.R. 834(a), 31 N.J.R. 1104(a).
 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).

EXHIBIT H

PLEASE DO NOT STAPLE IN THIS AREA

APR 70/REV 0538 0008

HEALTH INSURANCE CLAIM FORM

1a INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)

3 PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)

4 INSURED'S NAME (Last Name, First Name, Middle Initial)

5 PATIENT'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code)

6 PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other)

7 INSURED'S ADDRESS (No. Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE)

8 PATIENT STATUS (Employed, Full Time Student, Part Time Student)

9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10 IS PATIENT'S CONDITION RELATED TO (a) OTHER INSURED'S POLICY OR GROUP NUMBER (b) AUTO ACCIDENT? (c) OTHER ACCIDENT?

11 INSURED'S POLICY GROUP OR FECA NUMBER

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) SIGNED DATE

13 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.) SIGNED DATE

14 DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (IMP) (MM DD YY)

15 IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YY)

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO) (MM DD YY)

17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a ID NUMBER OF REFERRING PHYSICIAN

18 HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO) (MM DD YY)

19 RESERVED FOR LOCAL USE

20 OUTSIDE LAB? (YES NO) \$ CHARGES

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

22 MEDICAID RESUBMISSION CODE ORIGINAL REF NO

23 PRIOR AUTHORIZATION NUMBER

24	A		B		C		D	E	F	G	H	I	J	K
	From	To	Place of Service	Type of Service	PROCEDURES SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT HCPCS I MCDIQR	DIAGNOSIS CODE								
1														
2														
3														
4														
5														
6														

25 FEDERAL TAX ID NUMBER SSN EIN

26 PATIENT'S ACCOUNT NO

27 ACCEPT ASSIGNMENT? (For govt claims see back) (YES NO)

28 TOTAL CHARGE \$

29 AMOUNT PAID \$

30 BALANCE DUE \$

SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

31 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)

32 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE #

5111788 HCFA-1500 (JAN 81) 11-80 (CPL) (UC)

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90) FORM DWP-1500 FORM RRB-1500