

NEW JERSEY
INDIVIDUAL HEALTH COVERAGE PROGRAM

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ADVISORY BULLETIN 96-IHC-03

Date: December 19, 1996

To: IHC Member Carriers That Offer the Standard Health Benefits Plans and All Interested Parties

From: Ellen F. DeRosa, Assistant Director

Re: 1997 Policy Forms Modifications

The Individual Health Coverage Program Board (IHC Board) began considering modifications to the standard plans, A - E and HMO, earlier this year. While the IHC Board was in a position to propose and adopt 1995 and 1996 policy forms changes with January 1 effective dates, a number of factors have caused a delay in the proposal of the 1997 policy forms changes.

Many of the forms changes the IHC Board will propose in early 1997 involve clarifications to the current text rather than substantive eligibility or benefit changes. Since a number of the clarifications were considered in response to carrier inquiries, the purpose of this Bulletin is to provide guidance until such time as revised text is proposed and adopted. In the interim, carriers should take all reasonable steps to ensure that the administration of the standard plans is in accordance with the clarifications described in this Bulletin.

To make it easier to follow these clarifications, the order of presentation will follow the order in which the affected provisions first appear in the policy forms.

Clarifications to Plans A - E

Definitions: *Non-Covered Expenses*

Only expenses which are considered to be covered charges can be used to satisfy the cash deductible. Copayments and coinsurance are only applied to the extent that the expense is a covered charge. Therefore, the definition of Non-Covered Expense will be revised so that the deductible, copayment and coinsurance are not considered as Non-Covered Expenses.

Eligibility: Parent and Child(ren) Coverage

The term “parent” was intended to mean an “adult,” so the policy will be revised to refer to Adult and Child(ren) Coverage.

Eligibility: If Covered Under Another Individual Health Benefits Plan

[Refer also to the Termination provisions.] Since the eligibility section of the IHC Act does not contemplate the holding of duplicative coverage, the individual health benefits plans contain no provision for coordination of benefits. If a covered person elects to replace IHC coverage from one carrier with IHC coverage from another carrier, the replaced coverage terminates to coincide with the effective date of the new coverage. Provided the covered person notifies the replaced carrier within 30 days of the replacement, the carrier must refund premium for the period after the replaced coverage terminates. A carrier may not retain premium for any period after coverage ends if the covered person notified the carrier within 30 days of the replacement.

Schedule: Plans A and B

The inpatient cash deductibles in Plans A and B are intended to be hospital confinement copayments. In Plan A, the \$250 per day, for the first 5 days of a confinement, up to a maximum of \$2500 per benefit period, is a payment in lieu of the cash deductible. That is, the cash deductible does not apply to hospital confinement. In Plan B, the \$200 per day, for the first 5 days of confinement, up to a maximum of \$2000 per benefit period, is in addition to the cash deductible. For example, if a covered person is hospitalized for 7 consecutive days, he or she would be required to pay \$200 per day for the first 5 days (\$1000) **plus** the cash deductible, plus coinsurance.

Schedule: Therapy Services (Plans B - E)

[Refer also to the Therapy Services section of the Charges Covered with Special Limitations provision.] The plans cover 30 visits per benefit period for each of the following therapy services: physical therapy, occupational therapy, speech therapy and cognitive rehabilitation therapy.

Premium Rates and Provisions: Payment of Premiums - Grace Period

[Refer also to the Pre-Existing Condition Limitations section.] Coverage stays in force during the grace period. If a premium is not paid by the end of the grace period, coverage ends as of the end of the grace period. However, for the purpose of the continuity provisions of the pre-existing conditions limitation, the maximum 30 day lapse period should be measured for the paid-to-date, not the end of the grace period.

Charges Covered with Special Limitations: Mental or Nervous Conditions and Substance Abuse (Plans B - E)

The maintenance benefit is for the monitoring of a covered person’s use of maintenance prescription drugs. Charges for the maintenance prescription drugs and office visits to monitor the drugs are not subject to the internal limit applicable to treatment of mental or nervous conditions.

Clarifications to HMO Plan

Definitions: *Partial Hospitalization*

Any partial hospitalization treatment for mental or nervous conditions would directly offset the available outpatient coverage at the applicable 2:1 ratio.

Eligibility: *Parent and Child(ren) Coverage*

The term “parent” was intended to mean an “adult,” so the contract will be revised to refer to Adult and Child(ren) Coverage.

Eligibility: *If Covered Under Another Individual Health Benefits Plan*

[Refer also to the Termination provisions.] Since the eligibility section of the IHC Act does not contemplate the holding of duplicative coverage, the individual health benefits plans contain no provision for coordination of benefits. If a covered person elects to replace IHC coverage from one carrier with IHC coverage from another carrier, the replaced coverage terminates to coincide with the effective date of the new coverage. Provided the covered person notifies the replaced carrier within 30 days of the replacement, the carrier must refund premium for the period after the replaced coverage terminates. A carrier may not retain premium for any period after coverage ends if the covered person notified the carrier within 30 days of the replacement.

Premium Rates and Provisions: *Payment of Premiums - Grace Period*

Refer also to the Pre-Existing Condition Limitations section. Coverage stays in force during the grace period. If a premium is not paid by the end of the grace period, coverage ends as of the end of the grace period. However, for the purpose of the continuity provisions of the pre-existing conditions limitation, the maximum 30 day lapse period should be measured for the paid-to-date, not the end of the grace period. In the proposal, HMO carriers will be given the option to terminate coverage as of the paid-to-date as opposed to the end of the grace period, as an accommodation to those HMO carriers that would not be able to process a termination at the end of the grace period.

Covered Services and Supplies: *Therapy Services*

Respiration therapy, as defined in the contract, is a covered therapy service.

If you have any questions, please contact me at the phone or fax numbers shown above.