



State of New Jersey

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ADVISORY BULLETIN 15-IHC-02

October 28, 2015

To: IHC Program Member Carriers that Issue Coverage
IHC Program Interested Parties

From: Ellen DeRosa
Executive Director

Re: Adopted Amendments to Standard Plans A/50, B, C, D and HMO

In September 2015 the Individual Health Coverage Program Board (IHC Board) issued a rule proposal proposing amendments to the standard plans A/50, B, C, D and HMO. The IHC Board used the special rulemaking process set forth at N.J.S.A. 17B:27A-16.1 which allows for a comment period of at least 20 days after which the IHC Board may adopt the amendments. No comments were received during the public hearing on the amendments or during the period for written comments. At its meeting on October 13, 2015 the IHC Board voted to adopt the amendments as proposed. The notice of adoption has been filed and will appear in an upcoming *New Jersey Register*. The proposal and the adoption may be found on the following website:
http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrulesadoptions.htm

Recognizing that the process of reissuing policy and contract forms is both lengthy and costly the IHC Board determined it appropriate to give Carriers the option to implement the amendments to enforce policies and contracts by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D. Additionally, the IHC Board appreciates the lead time necessary for carriers to update issue systems for new business and will thus allow carriers to issue the 2015 forms with the Compliance and Variability Rider to new policyholders and new contractholders through the first quarter of 2016. By April 1, 2016, the IHC Board expects carriers will issue 2016 policies and contracts without the use of the Rider.

The text to be included on the Compliance and Variability rider is set forth below. Please note that Carriers must carefully review the text to determine which variable text should be included for each of the policies or contracts to be amended. Refer to the *Note to carriers* for guidance regarding items that may or may not be appropriate to include.

Please contact me with any questions at ellen.derosa@dobi.nj.gov

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Text to include on the Compliance and Variability Rider, Exhibit D, for Plans A/50 – D.

1. The **SCHEDULE OF INSURANCE** for the Catastrophic plan is amended as follows:

- The Per Covered Person Cash Deductible is increased to \$6,850.
- The Per Covered Family Cash Deductible is increased to \$13,700.
- The Per Covered Person Maximum Out of Pocket is increased to \$6,850.
- The Per Covered Family Maximum Out of Pocket is increased to \$13,700.

*[Note to carriers: Include **only** for the Catastrophic Plan. If included, adjust the numbering below.]*

1. The Vision benefits [and Dental Benefits] section[s] of **SCHEDULE OF INSURANCE** [is] [are] amended to state that benefits apply to Covered Persons through the end of the month in which the Covered Person turns age 19.

2. The **SCHEDULE OF INSURANCE** is amended to include the following service[s] under the Copayment section:

Telemedicine Visits [dollar amount not to exceed \$50]

E-Visits [dollar amount not to exceed \$50]

Virtual Visits [dollar amount not to exceed \$50]

*[Note to carriers: Include applicable text **only** by carriers offering an insured benefit for telemedicine, e-visits or virtual visits for which cost sharing is required. If included, adjust the numbering below.]*

2. The **DEFINITIONS** section is amended as follows:

- The first paragraph of the definition of **Dependent** is replaced with the following:

Dependent means Your:

- a) Spouse;
- b) Dependent child through the end of the month in which he or she attains age 26.

*[Note to carriers: Include **only** by carriers extending termination through the end of the month.]*

- The fourth paragraph of the definition of **Dependent** is replaced with the following:

In addition to the Dependent children described above, any other child over whom You have legal custody or legal guardianship may be covered to the same extent as a Dependent child under this Policy provided the child depends on You for most of the child's support and maintenance [and resides in Your household]. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, in Our Discretion.)

*[Note to carriers: Include **only** by carriers concerned with extending coverage in the absence of the household requirement for Marketplace plans.]*

- The definition of **Durable Medical Equipment** is expanded to state:
Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
- The definition of **Eligible Person** is replaced with the following:
Eligible Person means a person who is a Resident of New Jersey who is not covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). [An eligible person must be a U.S. Citizen, National or lawfully present in the United States.]

[Note to carriers: Include the text in brackets for Marketplace plans.]

- The following definition[s] of [E-Visit] [Telemedicine] [Virtual Visit] [is] [are] added.
E-Visit means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.

Telemedicine means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Covered Persons.

Virtual Visit means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate term(s) to define.]*

- The definition of **Triggering Event** is amended to add a new item.

The date of a court order that requires coverage for an Eligible Person.

3. The Spouse and Child Dependent items of the **Adding Dependents** section of the **ELIGIBILITY** provision are amended as follows:

Spouse - The following sentence is added: In case of a court order, coverage of a spouse as required by a court order will be effective as of the date specified in the court order.

Child Dependent – The third paragraph is amended to begin with the following clause: Except as stated below with respect to a court order. The following sentence is added: In case of a court order, coverage of a child dependent as required by a court order will be effective as of the date specified in the court order.

4. The **Maximum Out of Pocket** section of the **BENEFIT PROVISION** is replaced with the following:

Maximum Out of Pocket:

The Per Covered Person and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Covered Person, the Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Person, the per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per Covered Person Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the Calendar Year.

[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA. If included, adjust the numbering below.]

4. The **Practitioner's Charges for Non-Surgical Care and Treatment** section of the **COVERED CHARGES** provision is amended to add the following sentence[s]:

[We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate sentence(s) to include. If included, adjust the numbering below.]*

5. The **Durable Medical Equipment** section of the **COVERED CHARGES** provision is amended to add the following sentence:

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

6. The first paragraph of the **Dental Benefits** section of the **COVERED CHARGES** provision is replaced with the following:

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19 when services are provided by a [Network] provider.

*[Note to carriers: Include **only** by carriers issuing plans with embedded pediatric dental benefits. If included, adjust the numbering below.]*

6. The **Hearing Aids** section of the **COVERED CHARGES** provision is amended to add the following sentence:

Hearing aids are habilitative devices.

7. The first paragraph of the **Vision Benefit** section of the **COVERED CHARGES** provision is replaced with the following:

We cover the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19. We cover one comprehensive eye examination by a[n] [Network] ophthalmologist or optometrist in a 12 month period. [When purchased from a Network provider] We cover one pair of standard lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of standard frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

8. The **EXCLUSIONS** provision is amended as follows:

- Items a and b of the **Extraction of Teeth** exclusion are replaced with the following:
 - a) except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
 - b) except as otherwise stated in this Policy for Covered Persons through the end of the month in which he or she turns age 19 eyeglasses or lenses of any type; this exclusion does not apply to initial replacements for loss of the natural lens; or
- The **Telephone** consultations exclusion is replaced with the following:

Telephone consultations except as stated in the Practitioner's Charges for Non-Surgical Care and Treatment provision.

*[Note to carriers: Include **only** by carriers that added text to the Practitioner's Charges for Non-Surgical Care and Treatment provision.]*

Text to include on the Compliance and Variability Rider, Exhibit D, for HMO Plans.

1. The Vision benefits [and Dental Benefits] section[s] of **SCHEDULE OF SERVICES AND SUPPLIES** [is] [are] amended to state that benefits apply to Members through the end of the month in which the Member turns age 19.

*[Note to carriers: Include text **only** if the schedule of the plan specifies the age limit. If included, adjust the numbering below.]*

1. The **SCHEDULE OF SERVICES AND SUPPLIES** is amended to include the following service[s]:

TELEMEDICINE VISITS [dollar amount not to exceed \$50]

E-VISITS [dollar amount not to exceed \$50]

VIRTUAL VISITS [dollar amount not to exceed \$50]

*[Note to carriers: Include applicable text **only** by carriers offering an insured benefit for telemedicine, e-visits or virtual visits for which cost sharing is required. If included, adjust the numbering below.]*

1. The **DEFINITIONS** section is amended as follows:

- The first paragraph of the definition of **DEPENDENT** is replaced with the following:

DEPENDENT means Your:

- a) Spouse;
- b) Dependent child through the end of the month in which he or she attains age 26.

*[Note to carriers: Include **only** by carriers extending termination through the end of the month.]*

- The fourth paragraph of the definition of **DEPENDENT** is replaced with the following:

In addition to the Dependent children described above, any other child over whom You have legal custody or legal guardianship may be covered to the same extent as a Dependent child under this Policy provided the child depends on You for most of the child's support and maintenance [and resides in Your household]. (We may require that You submit proof of legal custody, legal guardianship, support and maintenance, in Our Discretion.)

*[Note to carriers: Include **only** by carriers concerned with extending coverage in the absence of the household requirement for Marketplace plans.]*

- The definition of **DURABLE MEDICAL EQUIPMENT** is expanded to state:
Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.
- The definition of **ELIGIBLE PERSON** is replaced with the following:
Eligible Person means a person who is a Resident of New Jersey who is not covered

under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). [An eligible person must be a U.S. Citizen, National or lawfully present in the United States.]

[Note to carriers: Include the text in brackets for Marketplace plans.]

- The following definition[s] of [E-Visit] [Telemedicine] [virtual Visit] [is] [are] added.
E-VISIT means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.

TELEMEDICINE means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Covered Persons.

VIRTUAL VISIT means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate term(s) to define.]*

- The definition of **PRIMARY CARE PHYSICIAN** is deleted and replaced with the following definition of **PRIMARY CARE PROVIDER**. Throughout the contract, all references to Primary Care Physician are amended to state Primary Care Provider.

PRIMARY CARE PROVIDER (PCP). A [Network] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre and post-natal care, birth and treatment of the diseases and hygiene of females,)] or pediatrics [or a [Network] provider who is a nurse practitioner/advanced practice nurse certified in advance practice categories comparable to family practice, internal medicine, general practice, [obstetrics/gynecology] or pediatrics] who supervises, coordinates, arranges and provides initial care and basic medical services to a [Member]; [initiates a [Member]'s Referral for Specialist Services;] and is responsible for maintaining continuity of patient care.

- The definition of **TRIGGERING EVENT** is amended to add a new item.

The date of a court order that requires coverage for an Eligible Person.

3. The Spouse and Child Dependent items of the **Adding Dependents** section of the **ELIGIBILITY** provision are amended as follows:

Spouse - The following sentence is added: In case of a court order, coverage of a spouse as required by a court order will be effective as of the date specified in the court order.

Child Dependent – The third paragraph is amended to begin with the following clause: Except as stated below with respect to a court order. The following sentence is added: In case of a court order, coverage of a child dependent as required by a court order will be effective as of the date specified in the court order.

4. The **Maximum Out of Pocket** section of the **COVERAGE PROVISION** is replaced with the following:

Maximum Out of Pocket:

The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the Calendar Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a Calendar Year. Once the Per Covered Family Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the Calendar Year.]

[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA. If included, adjust the numbering below.]

4. The **Outpatient Visits** subsection of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence[s]:

[We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate sentence(s) to include. If included, adjust the numbering below.]*

5. The **Durable Medical Equipment** subsection of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence:

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

6. The **Hearing Aids** subsection of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence:

Hearing aids are habilitative devices.

7. The **Vision Benefit** subsection of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to replace the first sentence with the following sentence:

We cover the vision benefits described in this provision for [Members] through the end of the month in which the Member turns age 19.

8. The first paragraph of the **Dental Benefits** section of the **COVERED SERVICES AND SUPPLIES** provision is replaced with the following:

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Members through the end of the month in which the Member turns age 19 when services are provided by a [Network] provider.

*[Note to carriers: Include **only** by carriers issuing plans with embedded pediatric dental benefits. If included, adjust the numbering below.]*

8. The **NON-COVERED SERVICES AND SUPPLIES** provision is amended as follows:

- Items a and b of the **Extraction of Teeth** exclusion are replaced with the following:
 - a) except as otherwise stated in this Contract for Members through the end of the month in which he or she turns age 19, exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
 - b) except as otherwise stated in this Contract for members through the end of the month in which he or she turns age 19, eyeglasses or lenses of any type; this exclusion does not apply to initial replacements for loss of the natural lens; or

- The **Telephone** consultations exclusion is replaced with the following:

Telephone consultations except as stated in the Outpatient Services provision.

*[Note to carriers: Include **only** by carriers that added text to the Outpatient Services provision.]*