



## State of New Jersey

DEPARTMENT OF BANKING AND INSURANCE  
INDIVIDUAL HEALTH COVERAGE PROGRAM  
PO Box 325  
TRENTON, NJ 08625-0325

CHRIS CHRISTIE  
*Governor*

RICHARD J. BADOLATO  
*Commissioner*

KIM GUADAGNO  
*Lt. Governor*

TEL (609) 633-1882  
FAX (609) 633-2030

PETER L. HARTT  
*Director*

### ADVISORY BULLETIN 17-IHC-02

November 8, 2017

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**

At its meeting on October 10, 2017 the IHC Board voted to adopt the amendments to the standard health benefits plans. 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](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 by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D.

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. After Carriers determine which text is appropriate for the plans to be amended the carrier may number or letter the items included on the rider.

Please contact me with any questions at [ellen.derosa@dobi.nj.gov](mailto:ellen.derosa@dobi.nj.gov)

## Compliance and Variability Rider Text for Plans A/50 – D

[The **SCHEDULE OF INSURANCE** is amended to include the following section:

**[Outpatient Surgery (facility charges)] Coinsurance Limit:**     \$[500] per [surgery]]

*Include only if outpatient surgery or some other service or supply for which coinsurance is required is subject to a limit.*

The **DEFINITIONS** section is amended:

- to delete the definitions of E-Visit and Virtual Visit;
- to replace the definitions of Preventive Care, Specialist Services, Telemedicine and Triggering Event with the following definitions; and
- to add the following definition of Telehealth.

**Preventive Care** means:

- a) Evidence based items or services that are rated “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the Covered Person;
- b) Immunizations for routine use for Covered Persons of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Covered Person;
- c) Evidence–informed preventive care and screenings for Covered Persons who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- d) Evidence–informed preventive care and screenings for Covered Persons as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- e) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening, and Nicotine Dependence Treatment.

**Specialist Services** mean Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of diseases and hygiene)].

**Telehealth** means the use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

**Telemedicine** means the delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance

between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

**Triggering event** means an event that results in an individual becoming eligible for a Special Enrollment Period. Triggering events are:

- a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
- b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
- c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
- d) [The effective date of a marketplace redetermination of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or no longer eligible for a subsidy] [*Note to Carriers, use this first clause for Marketplace plans.*] [The effective date of a marketplace redetermination that an Eligible Person is no longer eligible for a subsidy] [*Note to carriers for off-Marketplace plans.*].
- e) The date an Eligible Person gains or becomes a Dependent due to birth, adoption, placement for adoption, or placement in foster care; only the Eligible Person and new Dependents qualify for a triggering event.
- f) The date an Eligible Person gains or becomes a Dependent due to marriage provided at least one spouse demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of marriage; only the spouses qualify for a triggering event.
- g) The date NJFamilyCare determines an applicant who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
- h) The date an Eligible Person and his or her Dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
- i) The date an Eligible Person gains access to plans in New Jersey as a result of a permanent move provided the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
- j) The date of a marketplace or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
- k) The date of a court order that requires coverage for a Dependent.
- l) The date the Eligible Person demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

Note: The terms minimum essential coverage, marketplace, qualified health plan and subsidy have the meanings set forth in N.J.A.C. 11:20-1.2.

[ The last paragraph of the Primary Care Provider (PCP) section of the **EXCLUSIVE PROVIDER ORGANIZATION (EPO) PROVISIONS** is replaced with the following:

A Covered Person may use the services of a [XYZ] PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from the PCP. The Covered Person must obtain authorization from the PCP for other services.]  
*[Include only if referral is required for the EPO plan.]*

The **COVERED CHARGES** provision is amended to replace the **Practitioner's Charges for Non-Surgical Care and Treatment** section with the following:

We cover Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.  
*[Include only if policies were issued with text addressing telemedicine, e-visits or virtual visits.]*

The **COVERED CHARGES** provision is amended to add the following section:

**Practitioner's Charges for Telehealth and/or Telemedicine**

If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[The **EXCLUSIONS** provision is amended to replace the telephone consultations exclusion with the following:

**Telephone** consultations except as stated in the Practitioner's Charges for Telehealth and/or Telemedicine provision.]  
*[Include only if policies were issued with the prior exclusion and the carrier wishes to retain the exclusion.]*

## Compliance and Variability Rider Text for HMO Plans

[The **SCHEDULE OF SERVICES AND SUPPLIES** is amended to include the following section:

**[Outpatient Surgery (facility charges)] Coinsurance Limit:**     \$[500] per [surgery]]  
*Include only if outpatient surgery or some other other service or supply for which coinsurance is required is subject to a limit.*

The **DEFINITIONS** section is amended:

- to delete the definitions of E-Visit and Virtual Visit;

- to replace the definitions of Preventive Care, Primary Care Provider, Specialist Services, Telemedicine and Triggering Event with the following definitions; and
- to add a definition of Telehealth.

**PREVENTIVE CARE.** Preventive care means:

- f) Evidence based items or services that are rated “A” or “B” in the current recommendations of the United States Preventive Services Task Force with respect to the Member;
- g) Immunizations for routine use for Members of all ages as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention with respect to the Member;
- h) Evidence–informed preventive care and screenings for Members who are infants, children and adolescents, as included in the comprehensive guidelines supported by the Health Resources and Services Administration;
- i) Evidence–informed preventive care and screenings for Members as included in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- j) Any other evidence-based or evidence-informed items as determined by federal and/or state law.

Examples of preventive care include, but are not limited to: routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, prostate cancer screening, and Nicotine Dependence Treatment.

**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 diseases and hygiene,) 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.

**SPECIALIST SERVICES.** Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics][or obstetrics/gynecology (for routine pre and post-natal care, birth and treatment of diseases and hygiene)].

**TELEHEALTH.** The use of information and communications technologies, including telephones, remote patient monitoring devices, or other electronic means, to support clinical health care, Practitioner consultation, patient and professional health-related education, public health, health administration, and other services in accordance with the provisions of P.L. 2017, c. 117.

**TELEMEDICINE.** The delivery of a health care service using electronic communications, information technology, or other electronic or technological means to bridge the physical distance between a Practitioner and a Covered Person, either with or without the assistance of an intervening Practitioner, and in accordance with the provisions of P.L. 2017, c.117. Telemedicine does not

include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

**TRIGGERING EVENT.** An event that results in an individual becoming eligible for a Special Enrollment Period. Triggering events are:

- a) The date an Eligible Person loses eligibility for minimum essential coverage, or the Eligible Person's Dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace.
- b) The date a Dependent child's coverage ends as a result of attaining age 26 whether or not the Dependent is eligible for continuing coverage in accordance with federal or state laws.
- c) The date a Dependent child's coverage under a parent's group plan ends as a result of attaining age 31.
- d) [The effective date of a marketplace redetermination of an Eligible Person's subsidy, including a determination that an Eligible Person is newly eligible or no longer eligible for a subsidy.] [*Note to Carriers, use this first clause for Marketplace plans*] [The effective date of a marketplace redetermination that an Eligible Person is no longer eligible for a subsidy] [*Note to carriers for off-Marketplace plans.*].
- e) The date an Eligible Person gains or becomes a Dependent due to birth, adoption, placement for adoption, or placement in foster care only the Eligible Person and new Dependents qualify for a triggering event.
- f) The date an Eligible Person gains or becomes a Dependent due to marriage provided at least one spouse demonstrates having minimum essential coverage for one or more days during the 60 days preceding the date of marriage; only the spouses qualify for a triggering event.
- g) The date NJFamilyCare determines an applicant who submitted an application during the Open Enrollment Period or during a Special Enrollment Period is ineligible if that determination is made after the open enrollment period or special enrollment period ends.
- h) The date an Eligible Person and his or her Dependent child(ren) who are victims of domestic abuse or spousal abandonment need to enroll for coverage apart from the perpetrator of the abuse or abandonment.
- i) The date an Eligible Person gains access to plans in New Jersey as a result of a permanent move provided the Eligible Person demonstrates having minimum essential coverage for one or more days during the 60 days preceding the permanent move.
- j) The date of a marketplace or Carrier finding that it erroneously permitted or denied an Eligible Person enrollment in a qualified health plan.
- k) The date of a court order that requires coverage for a Dependent.
- l) The date the Eligible Person demonstrates to the marketplace or a State regulatory agency that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a Triggering Event.

Note: The terms minimum essential coverage, marketplace, qualified health plan and subsidy have the meanings set forth in N.J.A.C. 11:20-1.2.

The **COVERED SERVICES & SUPPLIES** provision is amended to replace item 1 of the **OUTPATIENT SERVICES** section with the following:

**Office visits** during office hours, and during non-office hours when Medically Necessary and Appropriate. *[Include only if policies were issued with text addressing telemedicine, e-visits or virtual visits.]*

The **COVERED SERVICES & SUPPLIES** provision is amended to add the following new item to the **OUTPATIENT SERVICES** section

**Practitioner's Charges for Telehealth and/or Telemedicine.** If a Network Practitioner provides Medically Necessary and Appropriate services through Telehealth and/or Telemedicine that are consistent with the requirements of P.L. 2017, c. 117 We cover such Network Practitioner's charges for services provided through Telehealth and/or Telemedicine.

[The **EXCLUSIONS** provision is amended to replace the telephone consultations exclusion with the following:

**Telephone consultations.** except as stated in the Outpatient Services provision.]

*[Include only if policies were issued with the prior exclusion and the carrier wishes to retain the exclusion.]*