State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
SMALL EMPLOYER HEALTH BENEFITS PROGRAM
PO BOX 325
TRENTON, NJ 08625-0325

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

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

RICHARD J. BADOLATO
Commissioner

PETER L. HARTT
Director

ADVISORY BULLETIN
16-SEH-02

October 20, 2016

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

From: Ellen DeRosa
Executive Director

Re: Adopted Amendments to Standard Plans B, C, D, HMO and HMO-POS

In July 2016 the Small Employer Health Benefits Program Board (SEH Board) issued a rule proposal proposing amendments to the standard plans B, C, D, HMO and HMO-POS and the SEH Board voted to adopt the amendments with non-substantial changes. 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 SEH Board determined it appropriate to give Carriers the option to implement the amendments to inforce policies and contracts by using the Compliance and Variability Rider set forth at N.J.A.C. 11:21 Appendix Exhibit DD. Additionally, the SEH Board appreciates the lead time necessary for carriers to update issue systems for new business and will thus allow carriers to issue the 2016 forms with the Compliance and Variability Rider to new policyholders and new contractholders through the first quarter of 2017. By April 1, 2017, the SEH 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 note that the rider text addresses the amendments that impact eligibility and benefit but does not address grammatical and similar types of amendments.

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

Text for Compliance and Variability Rider Plans B – E

Note to carriers: Adjust all numbers as necessary.

1. [Include language taglines as required by 45 C.F.R. 155.205(c)(2)(iii)(A)]

[2. All dollar limits for Out of Network Preventive Care [and Facility Charges for Ambulatory Surgical Centers] are deleted.]
Note to carriers: Include for plans with out of network benefits that included one or both of the limits.

3. The first paragraph of the **PARTICIPATION REQUIREMENTS** provision of the **GENERAL PROVISIONS** section of the group policy is deleted and replaced with the following:

> At least [75%] of the Full-Time Employees must be enrolled for coverage. If a Full-Time Employee is not covered by this Policy because:

Note to carriers: Include on the group policy rider but not on the certificate rider.

4. The **PAYMENT OF CLAIMS** provision of the **CLAIMS PROVISIONS** section is amended to include the following new paragraph:

> [Carrier] uses reimbursement policy guidelines that were developed through evaluation and validation of standard billing practices as indicated in the most recent edition of the Current Procedural Terminology (CPT) as generally applicable to claims processing or as recognized and utilized by Medicare. [Carrier] applies these reimbursement policy guidelines to determine which charges or portions of charges submitted by the Facility or the Practitioner are Covered Charges under the terms of the Policy.

Note to carriers: The above claims paragraph is variable text in the standard plan. Include this item on the rider if you are using the optional text.

5. The **DEFINITIONS** section is amended to delete the definitions of the terms listed below and replace the definitions with the definitions given below.

> **Allowed Charge** means an amount that is not more than the lesser of:
> • the allowance for the service or supply as determined by [Carrier] using the method specified below ; or
> • the negotiated fee schedule.
>
> *[Carrier must specify the method used to determine the allowed charge and explain how a covered person may learn the allowed charge for a service the [Covered Person] may receive.]*
>
> For charges that are not determined by a negotiated fee schedule, the [Covered Person] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

[Dependent means an Employee's:

a) legal spouse which, for purposes of dependent eligibility but not for purposes of the Employee definition, shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to: the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended; and the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.
b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

.

Note: If the Policyholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

Developmental Disability or Developmentally Disabled means a severe, chronic disability that:

a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the [Covered Person] attains age 26
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the [Covered Person's] need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Employee means an Employee of the Policyholder under the common law standard as described in 26 CFR 31.3401(c)-1. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are **not** employees of the Policyholder. Employee also excludes a leased employee.

Full-Time means a normal work week of [25] [30] or more hours. [Please note that the definition of Small Employer uses a definition of full-time that is used solely for the definition of Small Employer.] Work must be at the Policyholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

[Note to carriers: Use 25 for non-SHOP and include the please note sentence. Use 30 for SHOP policies.]

Preventive Care. As used in this Policy 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 female [Covered Persons] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; 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.

Small Employer means in connection with a Group Health Plan with respect to a Calendar Year and a Plan year, an employer who employed an average of at least 1 but not more than 50 Employees on business days during the preceding Calendar Year and who employs at least 1 Employee on the first day of the Plan Year.
All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of Employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 Employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time Employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time Employees to the number that results from the part-time Employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

Please note: Small Employer includes an employer that employs more than 50 full-time Employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

[Telemedicine means [a telephone][or] [an audiovisual] consultation between a [Network] Provider that has contracted with [Carrier] to offer telemedicine services and a Covered Person.]

Note to carriers: This is optional text. Include as appropriate.

6. The **Special Enrollment Rules** provision of the **EMPLOYEE COVERAGE** section is amended to include the following sentence:

If the triggering event is loss of minimum essential coverage the effective date may be as early as the day after the loss of minimum essential coverage.

7. Item f of the **When Dependent Coverage Ends** provision of the **DEPENDENT COVERAGE** section is deleted and replaced with the following:

f) at midnight [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.

8. The text explaining the use of emergency care services is expanded to further explain why calling within 48 hours or as soon as reasonably possible is required:
If a Covered Person receives Urgent Care or care and treatment for an Emergency from a non-[XYZ Health Care Network] provider, and the Covered Person calls [Carrier] within 48 hours, or as soon as reasonably possible, so [Carrier] will have the information necessary to provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a [XYZ Health Care Network] provider.

9. The second paragraph of the **CONTINUATION OF CARE** section is deleted and replaced with the following paragraphs:

[Carrier] shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

In case of a Covered Person in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Covered Person's condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

10. The **Prescription Drugs** provision of the **COVERED CHARGES** section is amended to include the following paragraph:

[Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two separate amounts. The first shipment will be for a 15-day supply. The [Covered Person] will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the [Covered Person] takes the medication. The [Covered Person's] cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the [Covered Person] does not wish to have a split fill of the medication, he or she may decline participation in the program. For those [Covered Persons] the Specialty Pharmacy will ship the full prescription amount and charge the [Covered Person] the cost share for the medication dispensed. Alternatively, the [Covered Person] may obtain the medication at a retail pharmacy.]

Note to carriers: The above prescription drugs text is optional. Include if applicable.

11. The **Dental Care and Treatment** provision of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** section is deleted and replaced with the following:

Dental Care and Treatment

This Dental Care and Treatment provision applies to all Covered Persons.

[Carrier] covers:

a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the later of:
    1. the date of the Injury; or
    2. the effective date of the Covered Person's coverage under this Policy.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

12. The **Preventive Care** provision of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** section is deleted and replaced with the following:

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density testing, colorectal cancer screening, prostate cancer screening and Nicotine Dependence Treatment.

13. The **EXCLUSIONS** section is amended to delete the following exclusion:

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Text for Compliance and Variability Rider for HMO and HMO-POS Plans

Note to carriers: Adjust all numbers as necessary.

1. Include language taglines as required by 45 C.F.R. 155.205(c)(2)(iii)(A)

[2. All dollar limits for Out of Network Preventive Care [and Facility Charges for Ambulatory Surgical Centers] are deleted.]
Note to carriers: Include for HMO-POS plans with out of network benefits that included one or both of the limits.

3. The **DEFINITIONS** section is amended to delete the definitions of the terms listed below and replace the definitions with the definitions given below.

ALLOWED CHARGE. Means an amount that is not more than the lesser of:
• the allowance for the service or supply as determined by Us using the method specified below ; or
• the negotiated fee schedule.

[Carrier must specify the method used to determine the allowed charge and explain how a covered person may learn the allowed charge for a service the Member may receive.]

For charges that are not determined by a negotiated fee schedule, the [Member] may be billed for the difference between the Allowed Charge and the charge billed by the Provider.

[DEPENDENT.
An Employee's:

a) legal spouse which, for purposes of dependent eligibility but not for purposes of the Employee definition, shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. [and domestic partner pursuant to P.L. 2003, c. 246]; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in Federal law with respect to:
- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986(COBRA), Pub. L. 99-272, as subsequently amended; and
- The provisions of this Contract regarding Medicare Eligibility by Reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent child [who is under age 26][through the end of the month in which he or she attains age 26].

Note: If the Contractholder elects to limit coverage to Dependent Children, the term Dependent **excludes** a legal spouse.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Eligibility** section of this Contract.

An Employee's " Dependent child" includes his or her legally adopted child, his or her step-child, his or her foster child, the child of his or her civil union partner, [and] [,the child of his or her domestic partner , and] children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

At Our discretion, We can require proof that a person meets the definition of a Dependent.]

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:

a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the [Member] attains age 26.
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the [Member's] need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or of extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

EMPLOYEE. An Employee of the Contractholder under the common law standard as described in 26 CFR 31.3401(c)-1. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are **not** employees of the Contractholder. Employee also excludes a leased employee.

FULL-TIME. A normal work week of [25] [30] or more hours. [Please note that the definition of Small Employer uses a definition of full-time that is used solely for the definition of Small Employer.] Work must be at the Contractholder's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

[Note to carriers: Use 25 for non-SHOP and include the please note sentence. Use 30 for SHOP policies.]

PREVENTIVE CARE

As used in the Contract 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 [Member];
b) 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];
c) 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;
d) Evidence–informed preventive care and screenings for female [Members] as included in the comprehensive guidelines supported by the Health Resources and Services Administration [except for contraceptive services and supplies]; 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.

PRIMARY CARE PROVIDER (PCP). A [Network] Practitioner 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 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. Primary Care Providers include nurse practitioners/clinical nurse specialists, physician assistants and certified nurse midwives.

SMALL EMPLOYER. Means in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, an employer who employed an average of at least 1 but not more than 50 Employees on business days during the preceding Calendar Year and who employs at least 1 Employee on the first day of the Plan Year.
All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer.

In the case of an Employer which was not in existence throughout the preceding Calendar Year, the determination of whether such employer is a small or large employer shall be based on the average number of Employees that it is reasonably expected such Employer will employ on business days in the current Calendar Year.

The following calculation must be used to determine if an employer employs at least 1 but not more than 50 Employees. For purposes of this calculation:
a) Employees working 30 or more hours per week are full-time Employees and each full-time Employee counts as 1;
b) Employees working fewer than 30 hours per week are part-time and counted as the sum of the hours each part-time Employee works per week multiplied by 4 and the product divided by 120 and rounded down to the nearest whole number.

Add the number of full-time Employees to the number that results from the part-time Employee calculation. If the sum is at least 1 but not more than 50 the employer employs at least 1 but not more than 50 Employees.

Please note: Small Employer includes an employer that employs more than 50 full-time Employees if the employer's workforce exceeds 50 full-time employees for no more than 120 days during the calendar year and the Employees in excess of 50 who were employed during such 120-day or fewer period were seasonal workers.

[TELEMEDICINE. A [telephone] [or] [an audiovisual] consultation between a [Network] Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].
Note to carriers: This is optional text. Include as appropriate.

4. The **Special Enrollment Rules** provision of the **EMPLOYEE COVERAGE** section is amended to include the following sentence:

If the triggering event is loss of minimum essential coverage the effective date may be as early as the day after the loss of minimum essential coverage.

5. Item f of the **When Dependent Coverage Ends** provision of the **DEPENDENT COVERAGE** section is deleted and replaced with the following:

f) at midnight [on the last day of the calendar month following] [on] the date the Dependent stops being an eligible Dependent.

6. The second paragraph of the **CONTINUATION OF CARE** section is deleted and replaced with the following paragraphs:

[Carrier] shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Member to continue treatment with the terminated health care professional and in certain cases of active treatment for up to 90 days, as described below.

In case of a Member in active treatment for a health condition for which the Provider attests that discontinuing care by the Provider would worsen the Member's condition or interfere with anticipated outcomes, coverage of the terminated Provider shall continue for the duration of the treatment, or up to 90 days, whichever occurs first.

7. The **Prescription Drugs** provision of the **COVERED SERVICES AND SUPPLIES** section [and of the **COVERED CHARGES APPPLICABLE TO NON-NETWORK BENEFITS** section][is] [are] amended to include the following paragraph:

[Specialty Pharmaceuticals Split Fill Program: Select Specialty Drugs will be eligible for a split fill when a new prescription that will be filled at a specialty pharmacy is prescribed. Under the split fill program an initial prescription will be dispensed in two

separate amounts. The first shipment will be for a 15-day supply. The [Member] will be contacted prior to dispensing the second 15-day supply in order to evaluate necessary clinical intervention due to medication side effects that may require a dose modification or discontinuation of the medication. The split-fill process will continue for the first 90 days the [Member] takes the medication. The [Member's] cost share (Copayment) amounts will be prorated to align with the quantity dispensed with each fill. If the [Member] does not wish to have a split fill of the medication, he or she may decline participation in the program. For those [Members] the Specialty Pharmacy will ship the full prescription amount and charge the [Member] the cost share for the medication dispensed. Alternatively, the [Member] may obtain the medication at a retail pharmacy.]

Note to carriers: The above prescription drugs text is optional. Include if applicable. If the plan is HMO-POS include the variable in the introductory sentence to address non-network benefits.

8. The **Dental Care and Treatment** provision of the **COVERED SERVICES AND SUPPLIES** section [and of the **COVERED CHARGES APPPLICABLE TO NON-NETWORK BENEFITS** section][is] [are] deleted and replaced with the following:

(k) **DENTAL CARE AND TREATMENT.**

Dental benefits available to all [Members]

The following services are covered for all [Members] when rendered by a [Network] Practitioner [upon prior Referral by a [Member's] Primary Care Provider]. We cover:

1) the diagnosis and treatment of oral tumors and cysts; and
2) the surgical removal of bony impacted teeth.

We also cover treatment of an Injury to natural teeth or the jaw, but only if:

1) the Injury was not caused, directly or indirectly by biting or chewing; and
2) all treatment is finished within 6 months of the later of:
   a) the date of the Injury; or
   b) the effective date of the Member's coverage under this Contract.

Treatment includes replacing natural teeth lost due to such Injury. But in no event do We cover orthodontic treatment.

Note to Carriers: Use the variable text if amending HMO-POS.

9. The **NON-COVERED SERVICES AND SUPPLIES [AND NON-COVERED CHARGES]** section is amended to delete the following exclusion:

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Note to Carriers: Use the variable text if amending HMO-POS.

10. The first paragraph of the **PARTICIPATION REQUIREMENTS** provision of the **GENERAL PROVISIONS** section of the group contract is deleted and replaced with the following:

At least [75%] of the Full-Time Employees must be enrolled for coverage. If a Full-Time Employee is not covered by this Contract because:

Note to carriers: Include on the group contract rider but not on the certificate rider.