EXPLANATION OF BRACKETS

Plans A/50 through D
(Appendix Exhibit A)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
b) Some areas of variability are noted with brief italicized explanations within the text. Examples include: use of high deductible health plan text and specialist copay.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
e) Some areas of variability are determined by the election made by a Carrier.
f) Some areas of variability are determined by the delivery system (i.e., indemnity or PPO)

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO plans, explicit guidance is set forth in item 15 below.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy forms.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
3. Deductible, and Co-Payments, as offered by the carrier, may be elected by the Policyholder, subject to the availability specified in regulation.
4. There are sample PPO schedule pages. There are corresponding provisions in the benefit provisions.
5. The list of services and supplies for which pre-approval is required includes some new items, included in brackets: specified therapies, therapeutic manipulation, exchange of non-biologically based mental illness inpatient days and prescription

drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.

6. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
7. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option delivery system.
8. The text describing provider compensation in the PPO section contains a number of bracketed words and phrases. Include the words and phases that describe the arrangement carrier has with network providers.
9. The continuation of care text must be included in all plans that use networks.
10. The treatment of hemophilia provision includes variable text that would only be included in PPO plans.
11. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
12. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
13. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy.
14. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
15. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:

    a. The policy and certificate documents contain “SAMPLE” schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:20-3.1(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use. ($15, $30, $40 or $50)

    b. Include the specific page of text describing the PPO mechanism, with specification of the name of the network or provider organization.
16. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
17. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

HMO Contract
(Appendix Exhibit B)

All text which is enclosed in brackets [ ] is variable. Enclosure in Brackets does ***not*** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], and [ABC].
b) Some areas of variability are noted with brief explanations within the text.
c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract form.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. Co-Payments may be elected by the Contractholder, subject to the availability specified in regulation.
4. Deductible, coinsurance and maximum out of pocket provisions may be included. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
5. The Contract includes referral text in brackets to allow the plan to be offered as a "gated" HMO or as a "non-gated" HMO.
6. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include.
7. OB/GYNs can be considered Primary Care Physicians.
8. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
9. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
10. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.