Each hour of the course duration shall consist of no less than 50 minutes of actual instruction, with no more than 10 minutes of each hour for administrative tasks.

(f) Material revisions of course content cannot be made without prior approval by the Commission, except where changes are made for the purpose of updating a course to reflect recent developments, such as the enactment of a new or amended law or rule, do not require prior approval. Any other changes shall be disclosed in application for reapproval of the course and submitted immediately.

11:5-12.14 Online continuing education courses; additional requirements

(a) Continuing education courses offered online shall include periodic progress assessments and a satisfactory level of performance by the licensee as a condition to continuing to a succeeding segment of the course.

(b) Except as limited at (b)1 below, online courses shall meet the following criteria:

1. The course is designed to promote active student engagement between the student and instructor, other students, or a computer program. Upon the recommendation of the Voluntary Advisory Committee, the Commission may approve a course that does not provide for such substantial interaction, but fulfills all other requirements set forth in this section and at N.J.A.C. 11:5-12.12 and 12.13;

2. The course, when taken without interruption, consists of no less than one hour of instruction, in accordance with N.J.A.C. 11:5-12.12(e);

3. The time required for course completion shall be at least equal to the number of credit hours assigned in accordance with N.J.A.C. 11:5-12.12(e), as verified by studies, field testing, or other means;

4. In addition to providing a notice to students setting forth the information referenced at N.J.A.C. 11:5-12.7(e), providers shall include information on how interaction is accomplished and any special requirements related to hardware, software, or any other equipment needed to complete the course;

5. Providers shall provide appropriate instructor and/or technical support for students to complete the course in the event of a hardware or software failure or interruption;

6. Providers shall use procedures that reasonably ensure the identity of the student and verification that the student receiving course credit is the individual who performed the course work;

7. Courses shall be equipped with a time-default mechanism for inactivity, so a student is not credited when not actively participating in the program; and

8. The provider shall obtain, electronically or through other means, a signed and dated statement from each student certifying that they personally completed the course.

(a)

DEPARTMENT OF BANKING AND INSURANCE

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program
Individual Health Benefits Plans

Adopted Amendments: N.J.A.C. 11:20 Appendix Exhibits A and B

Proposed: October 23, 2025 (see 57 N.J.R. 2655(a)).
Adopted: December 2, 2025, by New Jersey Individual Health Coverage Program Board, Sandi Kelly, Chairperson.
Filed: December 18, 2025, as R.2026 d.023, **without change**.

Authority: N.J.S.A. 17B:27A-2 et seq.

Effective Date: January 1, 2026.
Operative Date: April 1, 2026.
Expiration Date: December 12, 2031.

Summary of Hearing Officer's Recommendation and Agency's Response:

The New Jersey Individual Health Coverage Program Board (IHC Board) held a hearing on Wednesday, November 5, 2025, by Zoom to receive testimony with respect to the health benefits plans set forth at N.J.A.C. 11:20 Appendix Exhibits A and B. John Rossakis, Regulatory Officer, served as the hearing officer. There was no testimony at the hearing.

The hearing officer made no recommendations regarding the proposed amendments. The hearing record may be reviewed by contacting the New Jersey Individual Health Coverage Program Board, PO Box 325, Trenton, NJ 08625-0325.

Summary of Public Comment and Agency Response:

One comment was received regarding the proposed amendments. The comment was submitted by Jeanne McLaws, on behalf of Myriad Genetics, Inc.

COMMENT: The commenter requested that the IHC Board clarify that the carrier must cover Biomarker Precision Medical Testing if the testing is to be used "'for purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an individual's disease or condition' to guide treatment decisions and it satisfies any one of the five categories of medical and scientific evidence listed in [P.L. 2025, c.49]."

RESPONSE: Upon review, the Board declines to amend the proposed language. The proposed language reflects the statutory structure at P.L. 2025, c. 49 (Chapter 49) by providing coverage for Biomarker Precision Medical Testing when medically necessary for diagnosis, treatment, management, or monitoring, and when supported by ***any*** of the forms of evidence listed in the law (FDA approval/clearance, FDA-supported drug labeling, CMS national or local coverage determinations, or nationally recognized clinical guidelines). The proposed language is materially consistent with the statutory text and sufficiently conveys that satisfaction of any one of the categories is adequate for coverage. Accordingly, the IHC Board has determined that no further changes are necessary.

COMMENT: The commenter requested that the IHC Board clarify that carriers may not apply additional or different coverage criteria to restrict or limit coverage for Precision Biomarker Medical Testing when the testing meets requirements for coverage under a separate criterion listed at Chapter 49. The commenter provided the following example: "where a biomarker test is covered under Local Coverage Determinations of Medicare Administrative Contractors (LCD), an Insurer may not apply coverage criteria additional to or different from those included in the LCD to determine clinical utility."

The commenter further requested that the IHC Board include clarifying language requiring that insurers ensure that coverage be provided in a manner that limits disruption in care, including the need for multiple biopsies or biospecimens samples.

RESPONSE: The IHC Board declines to change the proposed language. Chapter 49 itself establishes the coverage criteria for Biomarker Precision Medical Testing and prohibits carriers from imposing inconsistent or more restrictive requirements. The proposed amendments mirror the statutory requirements by setting forth the categories of acceptable evidence, without authorizing the use of additional criteria imposed by the carrier. The IHC Board believes the text in the policy forms is sufficiently clear that carriers must provide coverage when the evidence standard is met; and that nothing in the proposed language is suggestive that carriers may layer additional clinical-utility criteria onto those established by statute. Therefore, the IHC Board has determined that no additional clarifying language is required.

COMMENT: The commenter requested clarification that carriers may not require multiple categories of evidence for coverage; must use the least-restrictive applicable criteria when multiple categories are met; and may not rely on more restrictive criteria (for example, under an LCD) when another category of evidence is satisfied.

RESPONSE: The IHC Board declines to change the proposed language. As stated above, the proposed language aligns with Chapter 49, which provides that any one of the listed categories of medical and scientific evidence is sufficient to establish clinical utility for coverage. The proposed language neither requires the application of more than one category, nor authorizes carriers to impose more restrictive coverage

criteria when multiple categories apply. As proposed, the rule text is sufficiently clear and consistent with the statute. Accordingly, the IHC Board has determined that no additional revisions are necessary.

COMMENT: The commenter requested that carrier medical policies explicitly cite Chapter 49 and state that its requirements supersede any conflicting or more general policy provisions, especially when a carrier utilizes multi-jurisdictional policies.

RESPONSE: The IHC Board declines to change the proposed language. Chapter 49 is binding law, requiring carriers to administer benefits in accordance with its provisions regardless of the specific format of their internal medical policies. The proposed amendments accurately and sufficiently incorporate the statutory requirements into the standard plan documents, without disturbing carriers' independent obligation to ensure compliance with Chapter 49. As the rule already reflects the operative statutory framework and does not create ambiguity regarding the primacy of State law, the IHC Board has determined that no additional language is necessary.

Federal Standards Statement

State agencies that propose to adopt or amend State rules that exceed Federal standards regarding the same subject matter are required to include in the rulemaking document a Federal standards analysis. As discussed in the notice of proposal, the amendments are intended to comply with newly enacted State law, and are not being adopted pursuant to the authority of, or in order to implement, comply with, or participate in, any program established pursuant to Federal law or a State statute that incorporates or refers to Federal law, standards, or requirements as set forth at N.J.A.C. 1:30-5.1(c)4. Accordingly, a Federal standards analysis is not required.

Full text of the adoption follows:

OFFICE OF ADMINISTRATIVE LAW NOTE: The New Jersey Individual Health Coverage Program Board is adopting amendments at N.J.A.C. 11:20 Appendix Exhibits A and B. Pursuant to N.J.S.A. 52:14B-7(c) and N.J.A.C. 1:30-5.2(a)2, the exhibits, as adopted, are not published in this notice of adoption, but may be reviewed by contacting:

New Jersey Individual Health Coverage Program
20 West State Street, 11th Floor
PO Box 325
Trenton, NJ 08625-0325
ihcsehprograms@dobi.nj.gov
or
New Jersey Office of Administrative Law
9 Quakerbridge Plaza
PO Box 049
Trenton, NJ 08625-0049
oal.comments@oal.nj.gov

(a)

DIVISION OF INSURANCE

Notice of Readoption
Dental Services

Readoption with Technical Changes: N.J.A.C. 11:10

Authorized By: Justin Zimmerman, Commissioner, Department of Banking and Insurance.

Authority: N.J.S.A. 17:1-8.1, 17:1-15.e, 17:48D-1 et seq., 17B:26-44.4 et seq., 17:48C-18.1 et seq., and 17B:27-51.10a et seq.

Effective Dates: December 17, 2025, Readoption;
January 20, 2026, Technical Changes.

New Expiration Date: December 17, 2032.

Take notice that pursuant to the provisions at N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 11:10 were scheduled to expire on January 25, 2026. The rules set forth the standards and practices for the regulation of dental plan organizations (DPOs) and the provision of dental services on other than a pure fee-for-service basis by insurers, DPOs, and dental service corporations (DSCs). The chapter includes the following subchapters:

N.J.A.C. 11:10-1 implements the Dental Plan Organization Act, N.J.S.A. 17:48D-1 et seq. (Act), which regulates persons and corporations offering plans for the payment of dental services. The Act provides for the licensing and supervision of DPOs to protect enrollees of the plans and to ensure that the services contracted for are delivered. This subchapter sets forth requirements for a DPO to obtain and maintain a certificate of authority, including criteria for written agreements with dentists and for evidence of coverage and group contract forms; financial reporting; general surplus, expense limitation, and fidelity bond and malpractice insurance requirements; enrollee complaint procedures; and standards for schedules of charges.

N.J.A.C. 11:10-2 requires employers or other organizations subject to this chapter to offer its employees or members the option of selecting alternative dental coverage. This subchapter includes notification requirements concerning alternative dental care aimed at employers and the health insurers, DPOs, and DSCs that issue dental plans.

The Department of Insurance (Department) has reviewed the rules at N.J.A.C. 11:10 and has determined the existing rules continue to be necessary, reasonable, and proper for the purposes for which they were originally promulgated. Accordingly, pursuant to N.J.S.A. 52:14B-5.1.c(1), these rules are readopted and shall continue in effect for a seven-year period, with technical changes to correct the Department's website. Specifically, the following technical changes are being made:

At N.J.A.C. 11:10-1.4(a) and 1.7(a), the Department's website address is corrected to: https://www.nj.gov/dobi/division_insurance/managedcare/dpo_app.pdf. At N.J.A.C. 11:10-1.4(a) and (e) and 1.7(a) and (e) names of internal units were updated, along with phone numbers and addresses for the Department and the National Association of Insurance Commissioners.

Full text of the technical changes follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 1. DENTAL PLAN ORGANIZATIONS

11:10-1.4 General rules

(a) Any person desiring to establish, operate**,** or administer a dental plan organization shall apply to the Commissioner for a certificate of authority. An application for a certificate of authority as a dental plan organization is available on the Department's website at [www.state.nj.us/dobi/division_insurance/managedcare/dpo_app.pdf] **https://www.nj.gov/dobi/division_insurance/managedcare/dpo_app.pdf** or can be obtained from:

New Jersey Department of Banking and Insurance
[Valuation Bureau
Life and Health Division]
Office of Solvency Regulation
Health Admissions
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
Phone: [609-292-5427] **609-292-7272**

(b)-(g) (No change.)

11:10-1.5 Written agreements with dentists

(a)-(e) (No change.)

(f) The written agreements and amendments shall be sent to:
[Chief, Health Insurance Bureau
Office of Life and Health]
Office of Managed Care
New Jersey Department of Banking and Insurance
20 West State Street
[P.O.] **PO** Box 325
Trenton, NJ 08625-0325

11:10-1.7 Financial reporting

(a) Every DPO shall submit a quarterly report and the DPO Supplement to the Quarterly Report for each of the first three calendar quarters ending March, June**,** and September within 45 days of the end of each quarter. Every DPO shall also submit the DPO Supplement to the