1. The following listing is not intended to be exhaustive, nor should it be interpreted as preventing county or municipal agencies from considering other situations not specifically mentioned in the list. Nevertheless, the agency shall confer with DFD if individual and/or family circumstances [which] **that** are offered as a reason for extending EA represent a departure from the categories provided herein. An extension of emergency assistance based on extreme hardship shall be provided when:

i. (No change.)

ii. There is imminent danger of the immediate breakup of the family unit, with children needing to be placed in [foster] **resource family** care;

iii.-v. (No change.)

2. (No change.)

(c)-(f) (No change.)

SUBCHAPTER 9. NOTICES AND HEARINGS IN WFNJ

10:90-9.1 Notice to applicant/recipient

(a)-(c) (No change.)

(d) Timely notice may be dispensed with**,** but adequate notice shall be sent not later than the effective date of the action when:

1.-6. (No change.)

7. An eligible child is removed from the home as a result of a judicial determination, an intervention by the Division of Child Protection and Permanency**,** or is voluntarily placed [in foster care] **outside of the home** by his or her legal guardian;

8.-13. (No change.)

SUBCHAPTER 19. KINSHIP CARE SUBSIDY PROGRAM (KCSP)

10:90-19.3 Determining eligibility for the KCSP

(a)-(c) (No change.)

(d) Sources of countable income reflect WFNJ/TANF income definitions found at N.J.A.C. 10:90-3.9(b) and include, but are not limited to, employment (including self-employment), rental income, Social Security (disability, retirement**,** or survivor's) benefits, State disability, rental property managed by an agent, worker's compensation, pensions/annuity/401K payments, alimony received, railroad retirement, General Assistance payments, TANF payments (excluding payments for the kinship child), unemployment, interest and dividend income, [veterans] **veterans'** benefits**,** and any child support received.

1. For purposes of determining kinship family eligibility, exempt income, as stipulated at N.J.A.C. 10:90-3.19, includes, but is not limited to, SSI benefits, and [foster care] payments **for resource family care** and shall be excluded from the 150 percent FPL income eligibility test in the same manner that such benefits are excluded when determining WFNJ/TANF eligibility. Any member of the family who receives SSI or [foster care benefits] **any child for whom CP&P is making a resource family care payment** is not counted as a member of the kinship family for this determination.

(e)-(i) (No change.)

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
Actuarial Services

Proposed Readoption with Amendments: N.J.A.C. 11:4

Proposed Repeals and New Rules: N.J.A.C. 11:4-13.3

Proposed New Rules: N.J.A.C. 11:4-13.4, 16.2A, 16.6A, and 19.2A

Proposed Repeals: N.J.A.C. 11:4-15 and 11:4-56 Appendix A

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

Authority: N.J.S.A. 17:1-8.1 and 17:1-15.e.

Calendar Reference: See Summary below for explanation of exception to calendar requirements.

Proposal Number: PRN 2018-103.

Submit comments by January 4, 2019, to:

Denise Illes, Chief
Office of Regulatory Affairs
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325
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E-mail: legsregs@dobi.nj.gov.

The agency proposal follows:

Summary

In accordance with N.J.S.A. 52:14B-5.1, the rules at N.J.A.C. 11:4 were scheduled to expire on September 28, 2018. In accordance with N.J.S.A. 52:14B-5.1.c(2), the timely filing of this notice of readoption with the Office of Administrative Law extends the expiration date by 180 days to March 27, 2019. The rules in this chapter were promulgated to implement many of the statutory requirements in Titles 17 and 17B of the New Jersey Statutes. N.J.A.C. 11:4 includes rules concerning life, health insurance, and property casualty insurance. N.J.A.C. 11:4 contains the following subchapters:

Subchapter 1, New Jersey Insolvent Health Maintenance Organization Assistance Association;

Subchapter 2, Life Insurance and Annuities Replacement;

Subchapter 3, Coupon Policies and Policies Containing Guaranteed Annual Endowment Benefits;

Subchapter 4, Passbooks Used in Connection with Coupon Policies or Policies Containing Guaranteed Annual Endowment Benefits;

Subchapter 5, (Reserved);

Subchapter 6, Minimum Reserve Standards for Individual and Group Health Insurance Contracts;

Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings;

Subchapter 8, Charitable Annuities;

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures;

Subchapter 10, (Reserved);

Subchapter 11, Life Insurance Disclosure;

Subchapter 12, Student Life Insurance;

Subchapter 13, Group Student Health Insurance;

Subchapter 14, Home Health Care Insurance Coverage;

Subchapter 15, Alcoholism Benefits (proposed for repeal);

Subchapter 16, Minimum Standards for Individual Health Insurance;

Subchapter 17, Health Insurance Solicitation;

Subchapter 18, Individual Health Insurance Rate Filings;

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits;

Subchapter 20, Blindness; Partial Blindness or Other Physical or Mental Impairments, Unfair Discrimination;

Subchapter 21, Limited Death Benefits Forms;

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables;

Subchapter 23, Minimum Standards for Medicare Supplement Coverage;

Subchapter 23A, Medicare Supplement-Under 50 Coverage;

Subchapter 23B, Medicare Supplement-Age 50 Through 64 Coverage;

Subchapter 24, Smoker and Nonsmoker Mortality Tables;

Subchapter 25, Funeral Insurance Policies;

Subchapter 26, Annuity Mortality Tables;

Subchapter 27, The 2001 Commissioner's Standard Ordinary (CSO) Mortality Table for Use in Determining Minimum Reserve Liabilities and Nonforfeiture Benefits;

Subchapter 27A, Preferred Mortality Tables for Use in Determining Minimum Reserve Liabilities;

Subchapter 28, Group Coordination of Benefits;

Subchapter 29, (Reserved);

Subchapter 30, Accelerated Death Benefits;

Subchapter 31, (Reserved);

Subchapter 32, Valuation of Life Insurance Policies;

Subchapter 33, Excess Interest Reserve Adjustment;

Subchapter 34, Long-Term Care Insurance;

Subchapter 35, Viatical Settlements;

Subchapter 36, (Reserved);

Subchapter 37, Selective Contracting Arrangements of Insurers;

Subchapters 38 through 39, (Reserved);

Subchapter 40, Life/Health/Annuity Forms;

Subchapter 40A, "40 States" File and Use Standards and Procedures;

Subchapter 41, Standards for Individual Life Insurance Policy Forms;

Subchapter 42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions;

Subchapter 43, Individual Annuity Contract Form Standards;

Subchapter 44, Standards for Contracts on a Variable Basis;

Subchapter 45, Periodic Reports;

Subchapter 46, Synthetic Guaranteed Investment Contract Forms;

Subchapter 47, Actuarial Requirements for Flexible-Factor Policy Forms;

Subchapter 48, Unfair Discrimination;

Subchapter 49, Mandated Diabetes Benefits;

Subchapter 50, Reimbursement of Inmate Health Care Costs;

Subchapter 51, (Reserved);

Subchapter 52, Life Insurance Illustrations;

Subchapter 53, Minimum Standards for Specified Disease and Critical Illness Coverages;

Subchapter 54, Benefits Standards for Infertility Coverage;

Subchapter 55, Pharmacy Cards;

Subchapter 56, Self-Funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements;

Subchapter 57, Mandated Benefits for Biologically-Based Mental Illness;

Subchapter 58, Discretionary Clauses;

Subchapter 59, Disclosure Requirements for Annuities Directly Solicited to Consumers;

Subchapter 59A, Suitability and Insurer Supervision Requirements for Annuities Directly Solicited to Consumers;

Subchapter 60, Limitations on the use of Specific Terms or Designations in the Sale of Life Insurance;

Subchapter 61, Retained Asset Accounts; and

Subchapter 62, Pharmacy Benefit Managers.

The rules serve two general purposes. First, they protect consumers by addressing issues, such as unfair discrimination, minimum standards for health insurance coverage, mandatory disclosures to purchasers of life insurance, solicitation of health insurance, and replacement of life insurance and annuities. Second, they provide guidance to the insurance industry regarding business-related matters, such as form filings, reserving standards, reporting of expense experience, and use of mortality tables.

The Department of Banking and Insurance (Department) reviewed the rules to determine their current effectiveness and viability and determined that the rules continue to provide the insurance industry and consumers with vital information and useful standards concerning many aspects of life and health insurance and property casualty insurance. Accordingly, the existing rules continue to be necessary, reasonable, and proper for the purpose for which they were originally promulgated and are herein proposed for readoption. In addition, the Department is proposing amendments, including amendments that align the rules with the Patient Protection and Affordable Care Act (ACA), originally, Pub. L. 111-148 as amended by Pub. L. 152 on March 30, 2010, and subsequent amendments thereto. The Department recognizes that in the future additional amendments may be proposed to N.J.A.C. 11:4, including additional amendments to Subchapter 56, Self-funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements, Minimum Standards for Individual Health Insurance. The current proposed amendments, new rules, and repeals are as follows.

Subchapter 2, which governs life insurance and annuities replacement, is proposed to be amended at N.J.A.C. 11:4-2.3(b), which concerns the duties of producers, to indicate that if an alternative form of notice regarding replacement of life insurance or annuities is sought to be used by the producer, rather than the form in the subchapter Appendix A, the form shall be submitted to the Department's Consumer Protection Services for approval by the Commissioner.

Subchapter 7, which concerns the procedure for the regulation of consent to higher rate filings, is proposed to be amended at N.J.A.C. 11:4-7.3(a) to reflect the Department's correct website address of www.dobi.nj.gov. In addition, at N.J.A.C. 11:4-7.3(b)9, the cross-reference to "(a)8ii" is proposed to be amended to reflect the correct cross-reference "(b)8ii."

Several amendments are proposed to N.J.A.C. 11:4-13, which governs group student health insurance. Specifically, N.J.A.C. 11:4-13.2, Definitions, is proposed to be amended to include definitions for the terms "carrier," "essential health benefits," and "preexisting condition." The Department notes that the definitions for "preexisting condition" and "essential health benefits" are necessary because student health plans are subject to the ACA, which requires that the plans include essential health benefits and prohibits the plans from applying limits/exclusions for preexisting conditions. In addition, definitions for "mandatory" and "optional" are proposed to be deleted. Existing N.J.A.C. 11:4-13.3 is proposed for repeal and replacement, so that the rules are consistent with the ACA, which provides that preexisting conditions shall not be excluded from coverage and carriers shall not limit coverage in any way based upon a preexisting condition. New N.J.A.C. 11:4-13.3 provides that preexisting conditions shall not be excluded from coverage, and that carriers shall not limit coverage in any way based upon a preexisting condition.

New N.J.A.C. 11:4-13.4 is being proposed to address rate and form filing requirements for fully insured student health plans. The Department notes that student health plans are subject to many of the same provisions of the ACA that apply to individual health benefits plans (see 45 CFR 147.145), including the prohibition on limiting or excluding benefits for the treatment of preexisting conditions, the requirement to cover essential health benefits, the requirement to meet a minimum actuarial value, and the requirement to comply with certain rating standards. Pursuant to the Centers for Medicare and Medicaid Services (CMS) guidance, the Department implemented a review of student health plan rates under Order No. A16-106. Subsequently, CMS advised in the 2019 Notice of Benefit and Payment Parameters that states did not have to perform student health plan rate review in order to qualify as an effective rate review state. Nevertheless, the Department has found that reviewing the rates of student health plans is appropriate given the similarities with the coverages required under the ACA for individual and small employer plans, and the review provides additional consumer protections. Thus, the Department is proposing new N.J.A.C. 11:4-13.4 to formalize and continue this review going forward.

Subchapter 15, which addresses benefits for the treatment of alcoholism, is proposed for repeal because these requirements have been

superseded by the requirements of P.L. 2017, c. 28, the New Jersey Substance Use Disorder Law.

N.J.A.C. 11:4-16 sets forth the minimum standards applicable to all individual health insurance policies offered in New Jersey. Because the ACA establishes standards for health benefits plans, which are a subset of individual health policies and the ACA standards are not always consistent with the minimum standards set forth in N.J.A.C. 11:4-16, it has become necessary to amend various provisions of N.J.A.C 11:4-16 to clarify the exceptions to the general standards that apply with respect to health benefits plans. Therefore, proposed new N.J.A.C. 11:4-16.2A sets forth definitions of general applicability for Subchapter 16 and includes a definition for "health benefits plan" and "spouse." The definition of health benefits plan is being proposed to help distinguish a subset of individual health insurance that is subject to Federal standards under the ACA that differ from New Jersey standards in some instances. The definition of spouse is added to clarify that spouse includes individuals of both the same, as well as opposite, genders, whether through a marriage, a domestic union, or a civil union, consistent with New Jersey's civil union law (P.L. 2006, c. 103).

N.J.A.C. 11:4-16.4(a)2 is proposed for amendment to clarify that "sickness" shall not be defined in plans that are not health benefits plans in a manner more restrictive than as follows: a sickness or disease that causes loss commencing while the policy is in force and that is not excluded under a preexisting condition limitation. Additionally, N.J.A.C. 11:4-16.4(a)3 is also proposed for amendment to add that preexisting conditions shall not be defined or applied in a health insurance policy that is a health benefits plan because the ACA does not permit application of preexisting condition exclusions or limitations.

N.J.A.C. 11:4-16.5(d), which provides that a limited benefit health policy that provides only social insurance benefits may be issued if certain conditions are met, is proposed to be deleted.

Recodified N.J.A.C. 11:4-16.5(e), (k), and (o) are proposed for amendment to update cross-references as the result of the recodification of N.J.A.C. 11:4-16.6, which is described below.

Recodified N.J.A.C. 11:4-16.5(h) is proposed for amendment to clarify that, for other than health benefits plans for which no preexisting conditions can be excluded, no policy shall exclude coverage for a loss due to a preexisting condition, except where it is specifically excluded by the terms of a policy.

Recodified N.J.A.C. 11:4-16.5(j) is proposed for amendment to clarify that health benefits plans shall not exclude: preexisting conditions, limitations, or exclusions (paragraph (j)1); treatment of mental illness or substance use disorders (paragraph (j)2); coverage for pregnancy and childbirth (paragraph (j)3); coverage for treatment arising from injury from attempted suicide (subparagraph (j)4ii); and coverage for hearing aids consistent with P.L. 2008, c. 126 (paragraph (j)10).

Recodified N.J.A.C. 11:4-16.5(n) is proposed to be amended to provide that waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions shall not be used in health insurance policies that are health benefits plans.

N.J.A.C. 11:4-16.6(a) is proposed for amendment to state that this section does not apply to individual health insurance policies that are health benefits plans. At N.J.A.C. 11:4-16.6(c), the Department is proposing to delete the phrase "both husband and wife" and substitute it with "spouses." Additionally, N.J.A.C. 11:4-16.6(d), (e), and (f) are proposed to be deleted because "basic hospital expense coverage," "basic medical-surgical expense coverage," and "major medical expense coverage" as set forth in those subsections are associated with plans that can no longer be offered or sold in this State due to the requirements of N.J.S.A. 17B:27A-2 et seq. The Department proposes to delete existing subsection (k) ("limited benefit health coverage").

The Department proposes new N.J.A.C. 11:4-16.6A, which addresses minimum standards for individual health benefits plans. This section provides that all individual health benefits plans shall comply with N.J.A.C. 11:20. In addition, this section provides conditions that must be met in a policy that provides a second surgical opinion benefit as follows: plans with a second surgical opinion benefit would have to include a definition of elective surgery; second surgical opinions will be rendered only by specialists who are clearly qualified in their field, who are independent of the physician who makes the original recommendation for surgery, and who have no financial interest in the outcome (for or against surgery) of their recommendations; a second surgical opinion cannot be mandatory (that is, payment of claims for elective surgery is conditioned on having obtained a second opinion), unless the insurer is able to provide to the insured names of qualified specialists who are within convenient access to the insured; and if the policy requires the insured to pay for any part of the second surgical opinion (copayment, deductible, maximum amount), the premium for the policy cannot exceed the premium payable for a comparable policy without second surgical opinion benefits, and the insurer shall disclose to the insured that his or her out-of-pocket expenses may exceed the expenses that would result from an otherwise comparable policy without a second surgical opinion benefit. Finally, this section provides that any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor, to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

N.J.A.C. 11:4-16.8(b)1 is proposed for amendment to clarify that no individual health insurance policy "that is not a health benefits plan," shall be delivered or issued for delivery in this State, unless the appropriate outline of coverage as set forth in that rule is completed. N.J.A.C. 11:4-16.8(c) through (f) are proposed for deletion because the policies to which those provisions were applicable are no longer permissible for sale in New Jersey pursuant to N.J.S.A. 17B:27A-2 et seq., and all individual health benefits plans are subject to the requirements of the ACA and other applicable disclosure requirements for such health benefits plans throughout Title 11 of the Administrative Code.

N.J.A.C. 11:4-17.3 is proposed for amendment to add a definition for "health benefits plan." The definition of health benefits plan is consistent with the Individual Health Coverage (IHC) definition (see N.J.S.A. 17B:27A-2).

N.J.A.C 11:4-17.5(a) is proposed for amendment to add language that exempts the solicitation of "health benefits plans" from the requirement of Subchapter 17 that licensees (as defined in the subchapter) shall diligently inquire of each applicant as to the existence of any health insurance on any proposed insured.

N.J.A.C. 11:4-18.2 is proposed for amendment to clarify that Subchapter 18, Individual Health Insurance Rate Filings, shall not apply to individual health benefits plans as defined by N.J.S.A. 17B:27A-2 et seq.

The Department is proposing to amend N.J.A.C. 11:4-19.2 to clarify that Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, does not apply to individual or group health benefits plans for which the provisions of pregnancy and childbirth benefits are not optional.

The Department is proposing to add new N.J.A.C. 11:4-19.2A, which adds a definition for "health benefits plan" to the subchapter. The definition of health benefits plan is consistent with the IHC definition (see N.J.S.A. 17B:27A-2).

N.J.A.C. 11:4-19.4(a) is proposed for amendment to read that each insurer "issuing plans that are not health benefits plans" shall make available benefits coverage for maternity care without regard to the marital status of its policyholders, subscribers, or other persons thereunder covered for expenses incurred in pregnancy and childbirth.

Subchapter 35, Viatical Settlements, is proposed for amendment to correct several statutory cross-references. Specifically, N.J.A.C. 11:4-35.1(a) is being amended to correct the cross-reference to the Viatical Settlements Act from N.J.S.A. 17B:30A-1, which was repealed, to N.J.S.A. 17B:30B-1. Similar cross-reference corrections are made in N.J.A.C. 11:4-35.2, 35.3(a), 35.12(b), 35.16(a), and 35.18(f) and (g).

N.J.A.C. 11:4-37.4(b)1 is proposed for amendment to correct the direction for filing of selective contracting arrangements from the Valuation Bureau to the Office of Managed Care in the Department and deletes paragraph (b)2, which references the Department of Health and Senior Services.

Several amendments are proposed to Subchapter 42, Group Life, Group Health, and Blanket Insurance: General Standards for Contract Provisions. N.J.A.C. 11:4-42.2 is proposed for amendment to add a definition of "group health benefits plan." The definition of "group health

benefits plan" tracks the definition of "health benefits plan" but limits it to groups.

N.J.A.C. 11:4-42.8(a)5 is proposed for deletion because the prior authorization provision contained in this provision related to inpatient and/or outpatient treatment for alcoholism is inconsistent with New Jersey law at P.L. 2017, c. 28.

N.J.A.C. 11:4-42.9(b), concerning provisions for pre-existing condition exclusions and limitations, is proposed for amendment, consistent with the ACA, to specifically state that group health benefits plans are not permitted to apply preexisting condition exclusions or limitations.

N.J.A.C. 11:4-42.11(a) is proposed for amendment to specify that a group health benefits plan may not include an exclusion for losses resulting from the covered person's use of alcohol or drugs.

Subchapter 50, Reimbursement of Inmate Health Care Costs, is proposed for amendment, at N.J.A.C. 11:4-50.5(c), to update the cross-reference for the definition of "emergency" to N.J.A.C. 11:24-1.2 and 11:24A-1.2.

Subchapter 52, Life Insurance Illustrations, is proposed for amendment, at N.J.A.C. 11:4-52.9(g), to correct the Department address to which insurers are directed to mail annual certifications for life insurance illustrations.

Several sections of Subchapter 56, Self-Funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements, are proposed for amendment. N.J.A.C. 11:4-56.2 is proposed for amendment to delete the definitions for "eligible employee" and "small employer" and add new definitions for "employee" and "small employer" consistent with the definitions in the ACA, the Employee Retirement Income Security Act at 29 U.S.C. § 1002, or as set forth in the Internal Revenue Code and respective implementing regulations. In addition, N.J.A.C. 11:4-56.3 is proposed for amendment to specify that the Checklist and Certification that assist the Department in verifying compliance with N.J.S.A. 17B:27A-48 will be available on the Department's website and to delete the reference to the subchapter Appendix A, as Appendix A is proposed for repeal

Several amendments are proposed to N.J.A.C. 11:4-57.3(b), which governs exclusions and benefit limits concerning mandated benefits for biologically-based mental illness. Specifically, N.J.A.C. 11:4-57.3(b) is proposed for amendment to clarify that carriers may apply preauthorization requirements to treatment of biologically-based mental illness, only if those requirements are applicable to treatments of physical illnesses and consistent with the requirements of the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) part of Public Law 110-343. The Department is also proposing to delete N.J.A.C. 11:4-57.3(b)1i to clarify that visit limits are prohibited. Finally, N.J.A.C. 11:4-57.3(b)2ii is proposed for amendment to clarify that preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if "consistent with MHPAEA."

This notice of proposal provides for a comment period of 60 days and, therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, is excepted from the provisions of N.J.A.C. 1:30-3.1 and 3.2 governing rulemaking calendars.

Social Impact

Many of the rules proposed for readoption with amendments, new rules, and repeals protect consumers. Readoption of these rules, such as those regarding mandatory disclosures to purchasers of life insurance, minimum standards for life and health insurance and annuities, solicitation of health insurance, and replacement of life insurance and annuities, will allow for the continuing protection of consumers. The benefits derived by the public from these rules continue to be significant; thus, the rules continue to be necessary.

The rules provide insurers with certain standards and procedures for their reserves, rate filings, and policy and contract form filings. These rules continue to be necessary, so that insurers may continue to rely on them in their daily operations and remain in compliance with the law.

The rules also enable the Department to fulfill its regulatory responsibilities under the law. Failure to readopt these rules would impair the Department's regulatory oversight of the insurance industry and would harm both consumers and insurers who have relied on these rules for protection and guidance. Accordingly, their continued effectiveness is necessary.

The Department notes that the rules proposed for readoption with amendments, new rules, and repeals align with the requirements of existing State and Federal law and that there is no new social impact associated with the updating of these rules.

Economic Impact

Failure to readopt the rules would prove costly to insurers who have relied on them for guidance in establishing standards and procedures in order to remain in compliance with the law. Without these rules, insurers would expose themselves to expenditures in issuing policy forms and contracts, submitting certain form filings and other data and reports to the Department, and maintaining reserves, without any assurance that they would in fact be complying with statutory or Department requirements. Accordingly, the rules proposed for readoption with amendments, new rules, and repeals remain necessary, so that insurers may continue to operate efficiently and effectively for the benefit of New Jersey insurance consumers.

The Department notes that the rules proposed for readoption with amendments, new rules, and repeals align with the requirements of existing State and Federal law and that there is no new economic impact associated with the updating of these rules.

The rules clearly impact consumers. Several of these rules address industry trade practices that directly relate to consumers' insurance buying experience and the quality of the products available in the market. Accordingly, continuing effectiveness of the rules (including, for example, health insurance solicitation, life insurance disclosures, life insurance and annuities replacement, minimum standards for individual health insurance, and minimum standards for Medicare supplement coverage) is necessary, so that consumers remain confident in the insurance products they purchase and ensure that consumers understand and obtain the benefits to which they are entitled.

The compliance requirements contained in the rules to which insurers are subjected are necessary for insurers to operate effectively and efficiently. Moreover, as stated above, the rules are necessary to ensure that consumers are spending their insurance dollars wisely and obtaining the benefits they properly expect. Accordingly, any minimal cost to insurers to continue to comply with the rules is far outweighed by their significance to consumers.

The Department will continue to incur the costs involved in implementing the rules currently contained in this chapter.

Federal Standards Statement

With the exception of Subchapters 13, 16, 19, 23, 23A, 23B, 42, 56, and 57, which are impacted by the Affordable Care Act, the rules contained in this chapter are not subject to any Federal requirements or standards. The Department notes that with respect to the rules mentioned above that are impacted by the ACA, the Department's standards align with existing Federal standards.

Jobs Impact

The Department does not anticipate any jobs will be lost or generated as a result of the rules proposed for readoption with amendments, new rules, and repeals. The Department invites commenters to submit any data or studies concerning the jobs impact of the rules proposed for readoption with amendments, new rules, and repeals together with their written comments on other aspects of this rulemaking.

Agriculture Industry Impact

The Department does not expect any agriculture industry impact from the rules proposed for readoption with amendments, new rules, and repeals as they concern life and health insurance.

Regulatory Flexibility Analysis

Few, if any, of the insurers regulated by the rules in this chapter are "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Several rules (for example, life insurance and annuities replacement) relate to the conduct of insurance producers, most of whom are "small businesses." The compliance, recordkeeping, and reporting requirements imposed by the rules are clearly defined in the rules themselves. Examples of current recordkeeping and/or reporting

requirements imposed by this chapter include the following: providing health insurance solicitation notices to applicants and maintenance of complaint records; providing life insurance buyer's guides to prospective purchasers; providing notices to purchasers in the replacement of life insurance and annuities; and requiring commercial and personal lines insurers to submit a specific application form to the Department for requesting higher rates. These compliance requirements, however, have been in existence for years, and any small businesses that must comply are already familiar and in compliance with these requirements.

The Department has determined that the current requirements as proposed to be readopted with amendments, new rules, and repeals continue to be necessary. The rules apply to all insurers or insurance producers, as the case may be, without regard to size. The Department considers the requirements imposed to be the minimum necessary to implement the applicable statutory mandates and to protect consumers. As such, no differentiation in requirements can be provided based upon business size. The Department is unaware that any provisions of the rules are excessively burdensome to "small businesses" or unnecessary.

Future annual costs of compliance with the rules are not expected to differ from current annual costs. The use of professional services currently required by the rules (for example, actuaries and underwriting professionals) will continue to be necessary.

Housing Affordability Impact Analysis

The rules proposed for readoption with amendments, new rules, and repeals will have no impact on the affordability of housing in New Jersey and are unlikely to evoke a change in the average costs associated with housing because the rules proposed for readoption with amendments, new rules, and repeals concern life and health insurance.

Smart Growth Development Impact Analysis

The rules proposed for readoption with amendments, new rules, and repeals will have no impact on smart growth and there is an extreme unlikelihood that the rules proposed for readoption with amendments, new rules, and repeals would evoke a change in the housing production in Planning Areas 1 or 2, or within the designated centers, under the State Development and Redevelopment Plan in New Jersey because the rules proposed for readoption with amendments, new rules, and repeals concern life and health insurance.

Racial and Ethnic Community Criminal Justice and Public Safety Impact

The Department has evaluated this rulemaking and determined that it will not have an impact on pretrial detention, sentencing, probation, or parole policies concerning adults and juveniles in the State. Accordingly, no further analysis is required.

Full text of the rules proposed for readoption may be found in the New Jersey Administrative Code at N.J.A.C. 11:4.

Full text of the rules proposed for repeal may be found at N.J.A.C. 11:4-13.3 and 15 and 11:4-56 Appendix A.

Full text of the proposed amendments and new rules follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

SUBCHAPTER 2. LIFE INSURANCE AND ANNUITIES REPLACEMENT

11:4-2.3 Duties of producers

(a) (No change.)

(b) If the applicant answers "yes" to the question regarding existing coverage referred to in (a) above, the producer shall present and offer to read to the applicant, not later than at the time of taking the application, a notice regarding replacements in the form as described in subchapter Appendix A, incorporated herein by reference, or other substantially similar form approved by the Commissioner **and submitted to Consumer Protection Services**. However, no approval of the Commissioner shall be required when revisions to the notice are limited to the deletion of references not applicable to the product being sold or replaced. The notice may be presented to the applicant either in writing via a hard copy or electronically.

1.-3. (No change.)

(c)-(d) (No change.)

SUBCHAPTER 7. PROCEDURE FOR THE REGULATION OF CONSENT TO HIGHER RATE FILINGS

11:4-7.3 Filing requirements

(a) Applications shall be filed with the Commissioner within 20 work days after the insured has signed it or within 20 work days of the inception date of the policy, whichever is earlier. All applications shall be made by filing the appropriate application form included in the Appendix to this subchapter as Exhibits A, B**,** and C, incorporated herein by reference. The application forms are also available on the Department's website at [www.njdobi.org] **www.dobi.nj.gov**. Applications shall be sent to the Department through the use of the NAIC electronic filing system SERFF (System for Electronic Rate and Form Filing).

(b) Each application shall include the following information:

1.-8. (No change.)

9. Underwriting information in support of the additional premium under [(a)8ii] **(b)8ii** above. In the case of automobile insurance, liability and physical damage, a copy of the abstract of driving record from the Motor Vehicle Commission shall be submitted. Such abstract is not required if the coverage applied for is excess coverage over the coverages and limits available under any residual market mechanism providing automobile insurance pursuant to statute. In the case of fire insurance, an inspection report, based upon an inspection performed by a qualified person, shall be submitted.

10.-11. (No change.)

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

11:4-13.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Carrier" means any entity subject to the insurance laws and rules of this State, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital or health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services. For purposes of this subchapter, carriers that are affiliated carriers shall be treated as one carrier.

"Essential health benefits" means the categories of health care services required to be covered as specified at 45 CFR 156.110.

…

["Mandatory" refers to a requirement that all students, or all students who are not already insured for the same or similar benefits under other coverages, must purchase the insurance or are billed for the coverage and must return a waiver form to obtain exemption from payment.

"Optional" means that the students may elect to purchase or to reject the insurance and are not requested to return a waiver form in order to be exempt from payment.]

"Preexisting condition" means a health condition that manifested itself on or before the effective date of coverage.

11:4-13.3 Prohibited provisions

Preexisting conditions shall not be excluded from coverage; carriers shall not limit coverage in any way based upon a preexisting condition.

11:4-13.4 Rate and form filing requirements for fully insured student health plans

(a) Carriers offering student health plans shall adhere to the following requirements for the filing of rates and forms:

1. Each carrier shall submit separate rate and policy form filings in System for Electronic Rate and Form Filing (SERFF) for each student health plan offered, identifying the filings using H22 Student Health Insurance TOI and H22.000 Student Health Insurance sub-TOI;

2. Forms shall be submitted as follows:

i. Forms shall be submitted at least 90 days prior to the effective date of the policy and shall include a certification that the form complies with the essential health benefits set forth in the benchmark plan selected by New Jersey in accordance with 45 CFR 156.100; or

ii. Forms shall be submitted through SERFF, consistent with (a)1 above, and shall include a certification that a previously filed form, identified in the certification by its form number and filing date, complies with the essential health benefits set forth in the benchmark plan selected by New Jersey in accordance with 45 CFR 156.100.

3. Student health plan rate filings shall be submitted at least 90 days before the effective date of the rates;

4. Student health plan rate filings must be submitted for all rate changes and shall include Parts I, II, and III of the Rate Review Justifications explained at http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RRJ-Instructions-Manual-20150401-Final.pdf; and

5. Carriers shall confirm in the actuarial certification submitted with Part III of the Rate Review Justification that the rates for New Jersey do not subsidize the carrier's student health plans in other states, and carriers shall also specify in the actuarial memorandum the following details:

i. Rate increase by plan and explanation of variation if it is not the same for all plans;

ii. Three years of experience and a description of the basis, which may be school specific;

iii. Explanation of adjustments to base data for unusually high or low volume of large claims;

iv. Show run-out date and incurred but not reported (IBNR) assumption;

v. Support for the trend assumptions, including adjustments made for large claims amounts;

vi. Services included in "other" category;

vii. Adjustments and support for the following factors:

(1) Changes in benefits, if any;

(2) Changes in morbidity, if any;

(3) Demographics changes, if any;

(4) Network changes, if any; and

(5) Other changes, if any.

viii. Credibility assigned to experience and credibility methodology used;

ix. Source and development of manual rate if experience is not 100 percent credible;

x. A rating example;

xi. Quality improvement expenses;

xii. Explanation of any variation in administrative costs by plan; and

xiii. Actuarial value screenshots demonstrating compliance with 60 percent minimum.

SUBCHAPTER 15. (RESERVED)

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

11:4-16.2A Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Health benefits plan" means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State. For purposes of this subchapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

"Spouse" means an individual legally married under the laws of this State, or under the laws of another jurisdiction; a domestic partner, pursuant to New Jersey law at P.L. 2003, c. 246; a civil union partner, pursuant to New Jersey law at P.L. 2006, c. 103; and a person legally joined in a same sex relationship in another jurisdiction if such relationship provides substantially all of the rights and benefits of marriage.

11:4-16.4 Policy definitions

(a) Except as provided hereafter, no health insurance policy delivered or issued for delivery in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this section.

1. (No change.)

2. "Sickness" shall not be defined **in health insurance policies that are not health benefits plans** more restrictively than **as follows:** a sickness or disease [which] **that** causes loss commencing while the policy is in force and [which] **that** is not excluded under a preexisting condition limitation. A definition may provide for a probationary period [which] **that** will not exceed 30 days from the effective date of the coverage of an insured person. Such probationary period shall not apply to newly-born children where immediate coverage is required by N.J.S.A. 17B:26-2. The definition may also be modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability**,** or similar law.

3. **Preexisting conditions shall not be defined or applied in a health insurance policy that is a health benefits plan. In all other plans,** "[Preexisting] **preexisting** condition" shall not be defined to be more restrictive than [subparagraphs i and ii] as stated **in (a)3i and ii** below. Subparagraph [i] **(a)3i** shall apply where the insurer uses an application form designed to elicit the complete health history of a prospective insured and, on the basis of the answers on that application, underwrites in accordance with the insurer's established standards. Subparagraph [ii] **(a)3ii** shall apply where the insurer elects to use a simplified application, with or without a question as to the applicant's health at the time of application, or elects not to use any application.

i.-ii. (No change.)

4.-17. (No change.)

11:4-16.5 Prohibited policy provisions

(a)-(c) (No change.)

[(d) A limited benefit health policy which provides only social insurance benefits (insurance which pays benefits when government mandated program benefits are not payable) may be issued if it meets the conditions stated at N.J.A.C. 11:4-16.6(e)3.]

[(e)] **(d)** (No change in text.)

[(f)] **(e)** A cash value or premium refund benefit may only be included in Disability Income Protection Coverage and only if it meets the conditions set forth in N.J.A.C. 11:4-16.6[(g)2]**(d)2**. No other policy shall provide a return of premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability or payment of dividends on participating policies.

Recodify existing (g) and (h) as **(f) and (g)** (No change in text.)

[(i)] **(h)** [Except where a condition is specifically excluded by the terms of the policy] **With respect to health insurance policies that are health benefits plans, carriers shall not limit or exclude coverage for preexisting conditions. For all other health insurance policies**, no policy shall exclude coverage for a loss due to a preexisting condition**, except where a condition is specifically excluded by the terms of the policy and in accordance with the following**:

1.-2. (No change.)

[(j)] **(i)** (No change in text.)

[(k)] **(j)** No policy shall limit or exclude coverage by type of illness, accident, treatment**,** or medical condition, except as follows:

1. Preexisting conditions other than congenital anomalies of a covered newborn dependent child**, except that for health benefits plans, no preexisting conditions, limitations, or exclusions are permitted at all**;

2. Mental or emotional disorders and drug addiction**; however, health benefits plans shall not exclude treatment of mental illness or substance use disorders**;

3. Normal pregnancy and childbirth**; however, health benefits plans shall not exclude coverage for pregnancy and childbirth**;

4. Illness, treatment**,** or medical condition arising out of:

i. (No change.)

ii. Suicide (while sane or insane), attempted suicide**,** or intentionally self-inflicted injury**; however, health benefits plans shall not exclude coverage for treatment arising from such injury**;

iii.-iv. (No change.)

5.-9. (No change.)

10. [Eye glasses] **Eyeglasses**, hearing aids**,** and examination**s** for the prescription or fitting thereof**; however, health benefits plans shall not exclude coverage for hearing aids consistent with P.L. 2008, c. 126**;

11.-12. (No change.)

[(l)] **(k)** A policy issued as a "Medicare supplement policy" pursuant to N.J.A.C. 11:4-16.6[(j)]**(g)** shall not include limitations or exclusions which are more restrictive than those of Medicare for any type of care covered under the policy.

Recodify existing (m)-(n) as **(l) and (m)** (No change in text.)

[(o)] **(n)** Except with respect to Medicare supplement policies as defined in N.J.A.C. 11:4-16.6[(j)] **(g)**, **and health insurance policies that are health benefits plans,** other provisions of this [regulation] **section** shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting disease, physical condition**,** or extra hazardous activity. Where waivers are required as a condition of issuance, renewal**,** or reinstatement, signed acceptance by the insured is required unless on initial issuance either the full text of the waiver is contained on the first page or specification page of the policy or prominent notice of the waiver appears on the first page or **the** specification page. Waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions shall not be used in Medicare supplement policies **or health insurance policies that are health benefits plans**.

[(p)] **(o)** Except as otherwise provided in N.J.A.C. 11:4-16.8(b)4, the terms "Medicare supplement**,**"[,] "Medigap**,**"[,] and words of similar import shall not be used unless the policy is issued in compliance with N.J.A.C. 11:4-16.6[(j)]**(g)**.

11:4-16.6 Minimum standards for benefits

(a) The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual health insurance policy shall be delivered or issued for delivery in this State [which] **that** does not meet the required minimum standards for the specified categories unless the Commissioner finds that such policies can be filed as a limited benefit health coverage and the outline of coverage complies with the appropriate outline in N.J.A.C. 11:4-16.8. **This section does not apply to individual health insurance policies that are health benefits plans.**

(b) (No change.)

(c) General rules include the following:

1.-2. (No change.)

3. In a family policy covering [both husband and wife] **spouses** the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definition of "noncancellable" or "guaranteed renewable**.**"[.] However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit ([e.g.] **for example**, age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the duration specified in said definition.

4.-22. (No change.)

[(d) "Basic hospital expense coverage" is a health insurance policy which provides coverage for a period of not less than 31 days for one period of hospital confinement of each covered person for expenses incurred for necessary treatment and services rendered as a result of injury or sickness for at least the following:

1. Daily hospital room and board, including general nursing care and special diets, in an amount not less than the lesser of:

i. 80 percent of the charges for semi-private accommodations; or

ii. The Statewide average semi-private hospital room and board charge at the time the policy is issued, as determined by the New Jersey Department of Health.

2. Miscellaneous hospital services, for expenses incurred for the charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than 80 percent of the charges incurred up to at least $1800 or 10 times the daily hospital room and board benefits; and

3. Hospital outpatient services, consisting of:

i. Hospital services on the day surgery is performed;

ii. Hospital services rendered within 72 hours after accidental injury, in an amount not less than $50; and

iii. X-ray and laboratory tests to the extent that benefits for such services would have been provided if rendered to an inpatient of the hospital, in an amount not less than $100.

4. Benefits provided under (d)1 and 2 above may be provided subject to a combined deductible amount not in excess of $100.00.

(e) "Basic medical-surgical expense coverage" is a health insurance policy which provides coverage for each covered person for expenses incurred for the necessary services rendered by a physician for treatment of injury or sickness for at least the following:

1. Surgical services in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. Those based on a relative value fee schedule with a maximum of at least $500 for the most severe procedure. Acceptable relative value fee schedules include, but are not limited to, the New York certified surgical fee schedule or the 1964 California Relative Value Schedule.

2. Anesthesia services consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical services rendered by a physician other than the physician (or his assistant) performing the surgical services in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. 15 percent of the surgical service benefit.

3. In-hospital services, consisting of physicians' services rendered to a person who is hospital confined, for treatment of injury or sickness other than that for which surgical care is required, in an amount not less than:

i. 80 percent of the reasonable charges; or

ii. One percent of the maximum surgical fee for each day for not less than 21 days during one period of confinement.

(f) Major medical expense coverage includes:

1. "Major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than $10,000; copayment by the covered person not to exceed 25 percent of covered charges; a deductible stated on a per person, per family, per illness, per benefit period or per year basis or combination of such bases, not to exceed five percent of the maximum limit under the policy. The policy shall provide at least the

following benefits for each covered person after application of the copayment percentage.

i. Daily hospital room and board expenses as defined in (b)1 above for a period of not less than 31 days during one period of hospital confinement;

ii. Miscellaneous hospital services for a maximum of not less than $1800 or 15 times the daily room and board rate if specified in dollar amounts during one period of hospital confinement;

iii. Surgical services to a maximum of not less than $600.00 for the most severe operation with the amounts provided for other operations reasonably related to such maximum amount;

iv. Anesthesia services for a maximum of not less than 15 percent of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthesia services at the same unit value as used for the surgical schedule;

v. In-hospital medical services as defined in (e)3 above;

vi. Out-of-hospital care consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, and diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;

vii. Prosthetic appliances, meaning artificial limbs or other prosthetic appliances (except replacements thereof);

viii. Casts, splints, trusses, or braces; and

ix. Not fewer than three of the following additional benefits for a maximum of such covered charges of not less than $1000:

(1) In-hospital private duty graduate registered nurse services;

(2) Convalescent nursing home care;

(3) Diagnosis and treatment by a radiologist or physiotherapist;

(4) Rental or special medical equipment, as defined by the insurer in the policy;

(5) Treatment for functional nervous disorders, and mental and emotional disorders; and

(6) Out-of-hospital prescription drugs and medications.

2. Alternatively, "major medical expense coverage" is a health insurance policy which provides hospital, medical and surgical expense coverage for each covered person to a maximum of not less than $25,000; copayment by the covered person not to exceed 25 percent of covered charges; a variable deductible on a per person, per family, per illness, per benefit period or per year basis or a combination of such bases, for at least the amounts described in (f)1i through ix above and which meets the following conditions:

i. The deductible is defined as the greater of a minimum deductible of not less than $1500 or the amount of other medical expense coverage.

ii. The amount of covered expenses required to be incurred during a claim qualification period cannot exceed the minimum deductible.

iii. The policy includes a provision allowing the insured to change the amount of the Minimum Deductible under stated conditions as to evidence of insurability, notice and effective date.

iv. An annual notice is sent to New Jersey insureds advising them of their right to change the Minimum Deductible if their circumstances have changed.

v. If the minimum deductible exceeds $10,000, the benefit period does not begin until covered expenses exceed the deductible.

vi. If the minimum deductible exceeds $10,000, the claim qualification period is not less than 18 months.]

[(g)] **(d)** "Disability income protection coverage" shall be subject to the following standards:

1. (No change.)

2. Elimination periods [which] **that** do not comply with [(g)1ii] **(d)1ii** above may be used on a supplemental basis as an additional benefit to an individual disability income policy [which] **that** otherwise complies with [(g)1ii] **(d)1ii**, if the insurer submits the following to the Department:

i. (No change.)

ii. A certification by an officer of the insurer that:

(1) (No change.)

(2) Supplemental individual disability income benefits [which] are not in compliance with [(g)1ii] **(d)1ii** above will only be used to provide additional coverage on an individual disability income policy issued by the insurer which has an elimination period/benefit period combination which is in compliance with [(g)1ii] **(d)1ii** above;

(3) The part of the coverage that complies with [(g)1ii] **(d)1ii** above represents at least 50 percent of the benefits provided by the policy; and

(4) Any changes made after issue will meet the requirements in [(g)2ii(1)] **(d)2ii(1)** through (3) above to ensure that compliance with [(g)ii] **(d)1ii** will be maintained.

3.-4. (No change.)

Recodify existing (h)-(j) as **(e)-(g)** (No change in text.)

[(k) "Limited benefit health coverage" is any health insurance policy which provides benefits that are less than the minimum standards for benefits required under N.J.A.C. 11:4-16.6(d), (e), (f), (g), (h), (i) and (j). Such policies may be delivered or issued for delivery in this State only if the outline of coverage required by N.J.A.C. 11:4-16.8(m) or (n) is completed and delivered as required by N.J.A.C. 11:4-16.8(b).]

11:4-16.6A Minimum standards for individual health benefits plans

(a) This section sets forth the minimum standards that are prescribed for individual health insurance policies that are health benefits plans.

(b) All individual health benefits plans shall comply with N.J.A.C. 11:20.

(c) No individual benefits plan shall be delivered or issued for delivery in this State that does not also meet the following required minimum standards for the specified categories:

1. In a policy that provides a second surgical opinion benefit, the following conditions must be met:

i. The benefit includes a definition of elective surgery that is sufficiently clear to permit the average insured to distinguish between "elective" and "nonelective" surgery;

ii. Second surgical opinions will be rendered only by specialists who are clearly qualified in their field, who are independent of the physician who makes the original recommendation for surgery, and who have no financial interest in the outcome (for or against surgery) of their recommendations. "Clearly qualified" will be deemed satisfied by board certification in the field of proposed surgery or in the field of medical specialization concerned with the organ involved. "Independent" will be assumed if names of qualified second opinion specialists are provided by the insurer, although the insurer may provide other methods of designating specialists that result in an equal degree of independence. "No financial interest" will be deemed to exist if the specialist providing a second opinion is prohibited from performing the recommended surgery, if his or her remuneration is not dependent on the nature of his or her recommendation, and if he or she has no financial involvement of any nature in a partnership, corporation, or office with the first physician recommending surgery, or the facility and/or location at which the surgery will occur;

iii. A second surgical opinion cannot be mandatory, unless the insurer is able to provide to the insured names of qualified specialists who are within convenient access to the insured. "Mandatory" means that payment of claims for elective surgery is conditioned on having obtained a second opinion; and

iv. If the policy requires the insured to pay for any part of the second surgical opinion (copayment, deductible, and/or maximum amount), the premium for the policy cannot exceed the premium payable for a comparable policy without second surgical opinion benefits, and the insurer shall disclose to the insured that his or her out-of-pocket expenses may exceed the expenses that would result from an otherwise comparable policy without a second surgical opinion benefit. See N.J.A.C. 11:4-16.8(d), (e), and (f) for disclosure requirements; and

2. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

11:4-16.8 Required disclosure provisions

(a) (No change.)

(b) Outline of coverage—general rules include:

1. No individual health insurance policy **that is not a health benefits plan** shall be delivered or issued for delivery in this State unless the appropriate outline of coverage in (c) through (n) below is completed as to such policy and:

i.-ii. (No change.)

2.-9. (No change.)

[(c) An outline of coverage regarding basic hospital expense coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4-16.6(d). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)
(POLICY NUMBER—WHEN AVAILABLE)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1. Basic Hospital Expense Coverage. This type of policy is designed to cover you for hospital expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital services, and hospital outpatient services. Benefits may be subject to any limitations and deductible set forth in the policy. Coverage is not provided for physicians' or surgeons' fees or unlimited hospital expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10-30) days to return it to the company and get your money back.

3. Annual Premium $ _____ You Pay $ _____ per _____.

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (_____ % of semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____) (_____ % of charges up to $_____)
Hospital Outpatient Services (List with any dollar limit)	$_____
Other Benefits (List)	_____

(You must pay a $_____ deductible each year before you can receive benefits.)

4. (A description of policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

5. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS, OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(d) An outline of coverage regarding basic medical-surgical expense coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4-16.6(e). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)
(POLICY NUMBER—WHEN AVAILABLE)
BASIC MEDICAL SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1. Basic Medical-Surgical Expense Coverage—This type of policy is designed to cover you for medical and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: surgical services, anesthesia services, and in-hospital medical services. Benefits are subject to any limitations and deductibles set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical and surgical expenses.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10-30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Surgical Services	(_____ % of doctor's reasonable charges) (varies with service performed, up to $_____ for most expensive service)
Anesthesia Services	(_____ % of doctor's reasonable charges) (up to _____% of amount paid for surgery)
In-hospital Medical Services	(up to $_____ per day for _____ days) (_____ % of reasonable charges)
Other Benefits (List)	_____

4. For policies providing a second surgical opinion benefit the Notice(s) shown below shall be included when applicable.

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires to you obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(e) An outline of coverage regarding policies combining basic hospital and medical-surgical expense in the form prescribed below shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4-16.6(d) and (e). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)
(POLICY NUMBER—WHEN AVAILABLE)
BASIC HOSPITAL AND MEDICAL-SURGICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1. Basic Hospital and Medical-Surgical Expense Coverage—This type of policy is designed to cover you for hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital and hospital outpatient services, surgical and anesthesia services, and in-hospital medical services. Benefits may be subject to limitations and deductibles set forth in the policy. Unlimited hospital or medical and surgical expenses are not covered.

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have (10-30) days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____.

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (_____% of semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____) (_____ % of charges up to $_____)
Hospital Outpatient	

Services $_____
(List with any dollar limit)
Surgical Services (_____ % of doctor's reasonable charges)
(varies with service performed, up to $_____ for most expensive service)
Anesthesia Services (_____ % of doctor's reasonable charges)
(up to _____% of amount paid for surgery)
In-hospital Medical Services (up to $_____ per day for _____ days)
(_____ % of reasonable charges)
Other Benefits (List) _____
(You must pay a $_____ deductible each year before you can receive benefits.)

4. For policies providing a second surgical opinion benefit, the Notice(s) shown below shall be included when applicable:

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires you to obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____.

(f) An outline of coverage regarding major medical expense coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of N.J.A.C. 11:4-16.6(f). The items included in the outline of coverage must appear in the sequence set forth as follows:

(COMPANY NAME & ADDRESS)
(POLICY NUMBER—WHEN AVAILABLE)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1. Major Medical Expense Coverage—This type of policy is designed to cover you for major hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. You are covered for: daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care. Benefits may be subject to deductibles, copayment provisions, or other limitations set forth in the policy. (Basic hospital or basic medical expense coverage is not provided.)

2. Read Your Policy Carefully—This outline of coverage briefly describes the important features of your policy. This is not the insurance contract. Only the policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY. REMEMBER, if you are not satisfied with your policy, you have 10-30 days to return it to the company and get your money back.

3. Annual Premium $_____ You Pay $_____ per _____

Benefit	Insurance Policy Pays
Hospital Room and Board	($_____ per day for _____ days) (_____% of semi-private charges for _____ days)
Miscellaneous Hospital Services	(up to $_____)
Out of Hospital Services	(_____% of covered charges)
Surgical Services	(_____% of doctor's reasonable charges) (varies with service performed, up to $_____ for most expensive service)
Anesthesia Services	(up to _____% of amount paid for surgery)
In-hospital Medical Services	(up to $_____ per day for _____ days) (_____% of reasonable charges)

Other Benefits (List) _____
(Benefits are subject to a $_____ deductible each _____.)
(Benefits are subject to a deductible of the greater of $_____ or the amount of benefits provided by other medical insurance.
Your copayment is (_____ % of eligible charges.)
(This policy will pay up to $_____ during the lifetime of the policy.)
(This policy will pay up to $_____ for each _____.)

4. For policies providing a second surgical opinion benefit the Notice(s) shown below shall be included when applicable.

NOTICE

This policy provides coverage for a second surgical opinion. However, your out-of-pocket expenses under this policy may be greater than your expenses under a similar policy which does not provide coverage for a second surgical opinion.

NOTICE

This policy requires you to obtain a second opinion before elective surgery is performed. If you fail to obtain the second opinion, benefits for surgery may be (denied or reduced).)

5. (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in 3 above.)

6. (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

7. (For policies providing coverage as defined at N.J.A.C. 11:4-16.6(d)2, include the following statement: "This policy allows you to change the minimum deductible if your circumstances should ever change. You will be reminded of your right to change the deductible each year.")

FOR ADDITIONAL INFORMATION ABOUT POLICY BENEFITS OR CLAIMS, TELEPHONE (COLLECT) (TOLL FREE) (LOCAL NUMBER) _____]

Recodify existing (g)-(o) as **(c)-(k)** (No change in text.)

SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION

11:4-17.3 Definitions

The following words and terms, when used in this subchapter shall have the following meanings unless the context clearly indicates otherwise.

…

"Health benefits plan" means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State. For purposes of this subchapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations.

Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

…

11:4-17.5 Replacement

(a) All licensees involved in the sale of individual health insurance**, other than health benefits plans,** shall diligently inquire of each applicant as to the existence of any health insurance on any proposed insured. The licensee shall obtain either in the application or in a separate form, a statement, dated and signed by the applicant, indicating whether any health insurance is presently in force, the names of the companies which issued the insurance, the type of coverage, and where possible the policy number.

(b)-(f) (No change.)

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

11:4-18.2 Applicability and scope

This [regulation] **subchapter** shall apply to all individual health insurance policies delivered or issued for delivery in this [state] **State**, except that it shall not apply to conversion policies issued pursuant to a contractual conversion privilege**,** [and] it shall not apply to credit health insurance as defined by N.J.S.A. 17B:29-2b**, and it shall not apply to individual health benefits plans as defined by N.J.S.A. 17B:27A-2 et seq**. Nothing in this [regulation] **subchapter** may be construed so as to limit or waive the responsibilities otherwise imposed on insurers, with respect to the form and content of individual health insurance policies, by N.J.S.A. 17B:26.1 et seq.

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

11:4-19.2 Scope

This subchapter shall apply to all group and individual health insurance policies as well as hospital and medical service corporation contracts delivered or issued for delivery in this State[. This subchapter shall not apply]**, except that this subchapter does not apply to individual or group health benefits plans, or** to health service corporation contracts**, for which the provisions of pregnancy and childbirth benefits are not optional**.

11:4-19.2A Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Health benefits plan" means a hospital and medical expense insurance policy, health service corporation contract, hospital service corporation contract, medical service corporation contract, health maintenance organization subscriber contract, or other plan for medical care delivered or issued for delivery in this State. For purposes of this subchapter, health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

11:4-19.4 Maternity benefits option

(a) Each insurer **issuing plans that are not health benefits plans** shall make available benefits coverage for maternity care without regard to the marital status of its policyholders, subscribers**,** or other persons thereunder covered for expenses incurred in pregnancy and childbirth.

(b)-(d) (No change.)

SUBCHAPTER 35. VIATICAL SETTLEMENTS

11:4-35.1 Purpose and scope

(a) The purpose of this subchapter is to implement N.J.S.A. 17B:[30A-1]**30B-1** et seq.**,** governing viatical settlements.

(b) (No change.)

11:4-35.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Act" means an Act concerning life insurance viatical settlements approved September [17, 1999] **22, 2005**, N.J.S.A. 17B:[30A-1]**30B-1** et seq.

…

11:4-35.3 General licensing requirements

(a) The Commissioner may issue or renew a viatical settlement provider's license, a viatical settlement broker's license, or a viatical settlement representative's license to any person who complies with the requirements of N.J.S.A. 17B:[30A-2]**30B-3** and this subchapter.

(b)-(f) (No change.)

11:4-35.12 Payment of the proceeds

(a) (No change.)

(b) Payment of the proceeds of a viatical settlement pursuant to N.J.S.A. 17B:[30A-8d]**30B-9d** shall be by means of wire transfer to the account of the viator or by certified check or cashier's check.

(c) (No change.)

11:4-35.16 Disclosure

(a) A disclosure document containing the disclosures required in N.J.S.A. 17B:[30A-7]**30B-8** and this subchapter shall be provided to the viator before or concurrent with taking an application for a viatical settlement contract.

(b)-(d) (No change.)

11:4-35.18 Imposition of administrative penalties/suspension/revocation of license

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

(f) If no response is received within the time provided in any notice to suspend or revoke a license or authority to conduct any activity regulated by N.J.S.A. 17B:[30A-1]**30B-1** et seq., the Department shall prepare a final order suspending or revoking the license or authority to conduct such activity, and mail a copy of the order to the violator at the violator's last known business address on file with the Department.

(g) If the notice issued pursuant to this section provided for the payment of any fine, restitution**,** or reimbursement to the Department for investigative or examination cost, and payment or proof of payment has not been received, the Department may proceed without further notice to suspend or revoke the license or authority of the violator as provided at N.J.S.A. 17B:[30A-3]**30B-4**.

(h)-(n) (No change.)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

11:4-37.4 Selective contracting arrangement approval and amendment procedures

(a) (No change.)

(b) For the purposes of obtaining the Commissioner's approval under this subchapter, a carrier issuing health benefit plans utilizing a selective contracting arrangement shall submit four copies of a complete selective contracting arrangement approval application on a form to be provided by the Department.

1. Two copies of the entire application shall be submitted to the Department at the following address:

New Jersey Department of Banking and Insurance
[Valuation Bureau, 11th floor
Office of Life and Health]
Office of Managed Care, 9th floor
Consumer Protection Services
20 West State Street
[P.O.] **PO** Box 325
Trenton, NJ 08625-0325

[2. Two copies of the entire application, together with the appropriate filing fee set forth at N.J.A.C. 11:4-37.8, shall be submitted to the Department of Health and Senior Services at the following address:

New Jersey Department of Health and Senior Services
Office of Managed Care
John Fitch Plaza, Room 600
Warren and Market Streets
P.O. Box 360
Trenton, NJ 08625-0360]

(c)-(f) (No change.)

SUBCHAPTER 42. GROUP LIFE, GROUP HEALTH**,** AND BLANKET INSURANCE: GENERAL STANDARDS FOR CONTRACT PROVISIONS

11:4-42.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

"Group health benefits plan" means a hospital and medical expense insurance policy or certificate, health service corporation contract or certificate, hospital service corporation contract or certificate, medical service corporation contract or certificate, health maintenance organization subscriber contract or certificate, or other plan for medical care delivered or issued for delivery in this State to a small employer group pursuant to N.J.S.A. 17B:27A-19, or a large employer, or any other similar contract, policy, or plan issued to an employer not explicitly excluded from the definition of health benefits plan at N.J.S.A. 17B:27A-2, and rules promulgated pursuant thereto at N.J.A.C. 11:20. For purposes of this subchapter, group health benefits plan shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; stop loss or excess risk insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, as specified in Federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. Group health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan; limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Group health benefits plans shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to such an event under any group health plan maintained by the same plan sponsor. Group health benefits plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

…

11:4-42.8 Provisions setting forth pre-authorization requirements

(a) Group policies and certificates providing health insurance in which some portion of the benefits are subject to pre-authorization provisions shall comply with the following:

1.-4. (No change.)

[5. Inpatient and/or outpatient treatment for alcoholism as described at N.J.S.A. 17B:27-46.1 shall only be subject to pre-authorization provisions if all inpatient and/or outpatient treatments for other injuries and illnesses are subject to the same review.]

(b)-(c) (No change.)

11:4-42.9 Provisions for pre-existing condition exclusions and limitations

(a) (No change.)

(b) Group policies and certificates providing health insurance benefits, other than accidental death and dismemberment **and group health benefits plans**, may include pre-existing condition exclusions and limitations subject to the following:

1.-4. (No change.)

11:4-42.11 Provisions concerning exclusions and limitations for the use of alcohol and drugs or relating to illegal occupations

(a) A blanket insurance policy or certificate or other group policy or certificate providing health insurance**, other than a group health benefits plan,** may include an exclusion for losses resulting from the covered person's use of alcohol or drugs, but such exclusion shall be worded no more restrictively than as follows:

"The insurer shall not be liable for any loss sustained or contracted as a consequence of the covered person's intoxication or being under the influence of any narcotic unless administered or consumed on the advice of a physician."

(b) (No change.)

SUBCHAPTER 50. REIMBURSEMENT OF INMATE HEALTH CARE COSTS

11:4-50.5 Health coverage plans

(a)-(b) (No change.)

(c) Notwithstanding the provisions of N.J.A.C. [8:38-1.2] **11:24-1.2 and 11:24A-1.2** (definition of "emergency"), it shall be presumed that inmates are in need of emergency medical care and are not located in a place where it can be rendered by any network health care provider. The institutional medical health care provider is deemed to be the inmate's only available source of medical care.

(d) (No change.)

SUBCHAPTER 52. LIFE INSURANCE ILLUSTRATIONS

11:4-52.9 Annual certifications

(a)-(f) (No change.)

(g) The annual certifications shall be provided to the Commissioner each year by a date determined by the insurer. Subsequent annual certifications shall be provided by the anniversary date of the initial annual certification, or a request to change the date of certification with a full explanation of the basis of the request shall be filed by that date. The original certification shall be mailed to the following address:

New Jersey Department of Banking and Insurance
[Division of Enforcement and Consumer Protection]
Life and Health Actuarial
[P.O.] **PO** Box [329] **325**
Trenton, New Jersey 08625-[0329]**0325**

(h) (No change.)

SUBCHAPTER 56. SELF-FUNDED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS AND INSURED MULTIPLE EMPLOYER ARRANGEMENTS

11:4-56.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

…

["Eligible employee" means a full-time employee who works a normal workweek of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under the health benefits plan of a small employer, but does not include employees who work less than 25 hours a week, work on a temporary or substitute basis or are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.]

"Employee" means an individual who is an employee under the common law standard as described in 26 CFR 31.3401(c)-1. For purposes of determining whether an employer is a small employer, employee excludes an individual and his or her spouse when the business is owned by the individual or by the individual and his or her spouse, a sole proprietor, a partner in a partnership, and a two percent shareholder in a Subchapter S corporation, as well as immediate family members of such individuals. Employee also excludes a leased employee.

…

["Small employer" means any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year, and the majority of employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer.]

"Small employer" means in connection with a group health plan with respect to a calendar year and a plan year, an employer with a business location in the State of New Jersey who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

Any person treated as a single employer under Subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (26 U.S.C. § 414) shall be treated as one employer. Additionally, 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. As used in the definition of small employer, full-time means an employee that works 30 or more hours per week.

…

11:4-56.3 Initial registration of self-funded MEWAs

(a) By September 5, 2004, a self-funded MEWA operating in this State prior to June 7, 2004**,** shall file an application for initial registration with the Commissioner. A self-funded MEWA that was not operating in this State prior to June 7, 2004**,** shall not commence operations in this State until it submits an application for initial registration to the Commissioner, and said application is approved. The application for registration shall be on a form prescribed by the Commissioner **available on the Department's website at https://www.state.nj.us/dobi/division_insurance/mewaapps.htm**, and shall include the following:

1. (No change.)

2. A completed Checklist and Certification [(incorporated herein by reference as subchapter Appendix A), along with specimen forms, for each small employer plan of benefits offered by the self-funded MEWA] **with information regarding administration, underwriting requirements, and coverage services that assists the Department in verifying compliance with N.J.S.A. 17B:27A-48 can be found on the Department's website at: www.state.nj.us/dobi/division_insurance/lifehealthmain.html**;

3.-15. (No change.)

(b)-(f) (No change.)

APPENDIX A (RESERVED)

SUBCHAPTER 57. MANDATED BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS

11:4-57.3 Exclusions and benefit limits

(a) (No change.)

(b) Subject to (a) above, carriers may apply [benefit limits, including] preauthorization requirements, to treatment of biologically-based mental illness only if those [benefit limits, including preauthorization] requirements[,] are applicable to treatments of physical illnesses[. Visit limits and preauthorization requirements may be applied only to the extent stated in (b)1 and 2 below.] **and consistent with the requirements of the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) part of Public Law 110-343, and further:**

1. Visit limits **are prohibited**[:]**; and**

[i. Visit limits may be applied to therapy for the treatment of biologically-based mental illness if the same visit limits are applied to therapy for the treatment of physical illness. For example, a limit of 30 speech therapy visits per year is permitted for speech therapy that is required to treat a biologically-based mental illness (such as autism or pervasive developmental disorder), so long as the limit also applies to speech therapy that is required to treat a physical illness (such as stroke).]

2. Preauthorization requirements:

i. [Preauthorization] **A carrier shall not require preauthorization** of all services to treat biologically-based mental illness**, this means** [(]that [is,] blanket preauthorization[)] is not permitted.

ii. Preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if [preauthorization is required for the same or similar services when provided to treat physical illness. For example, a carrier may require preauthorization of partial day hospitalization for the treatment of biologically based mental illness if it also requires preauthorization of intensive outpatient treatments for physical illness such as outpatient surgery, chemotherapy or radiation therapy] **consistent with MHPAEA**.