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DEPARTMENT OF BANKING AND INSURANCE
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ADVISORY BULLETIN
14-SEH-03

November 25, 2014

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

From: Ellen DeRosa
Executive Director

Re: Adopted Amendments to the Standard Plans for 2015

The Small Employer Health Benefits Program Board (SEH Board) proposed amendments to the standard plans in October 2014 using the special rulemaking process set forth in N.J.S.A. 17B:27A-51. The comment period ended and the SEH Board voted to adopt the amendments on November 19, 2014. The Operative Date for the adopted amendments is January 1, 2015. Information on the proposal and adoption can be found on our website at the following address:
http://www.state.nj.us/dobi/division_insurance/ihcseh/sehrulesadoptions.htm

Use of Compliance and Variability Rider

Given the nature and extent of the amendments to the standard plans and the fact that Carriers recently issued new policies and certificates consistent with the 2014 standard plans, the SEH Board determined that Carriers may use Exhibit DD, the Compliance and Variability Rider, to accomplish the 2015 amendments for inforce plans. In addition, to allow time to update Carrier issue systems, the Rider may be used for newly issued policies and certificates through April 2015. The SEH Board expects that Carriers will issue new policies and certificates using the 2015 forms no later than May 1, 2015.

Questions?

If you have any questions please send them by email to ellen.derosa@dobi.state.nj.us.

Text to Include on the Compliance and Variability Rider, Exhibit DD, for Plans B – E.

1. The **Payment Limits** section of the **SCHEDULE OF INSURANCE** is amended to replace the two sections of text addressing charges for therapy under the Autism and Other Developmental Disabilities Provision with the following text:

> Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision
> 30 visits
> Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.
>
> Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) 30 visits
> Note: These services are habilitative services in that they are provided to help develop rather than restore a function. The 30-visit limit does not apply to the treatment of autism.

2. The **PAYMENT OF PREMIUMS – GRACE PERIOD** provision in the **GENERAL PROVISIONS** section is replaced with the following:

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Policyholder to [Carrier] [[XYZ] for remittance to [Carrier]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]* Each may be paid at a [Carrier's] [XYZ's] office [or to one of its authorized agents.] A premium payment is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums for the time this Policy is in force.

[Note to carriers: This amendment applies ONLY to Group Policies issued to employers that purchased coverage through the SHOP. It does not apply to Certificates issued to employees whose employers bought coverage through the SHOP.

If this amendment is not included, re-number the following amendments accordingly.]

3. The **DEFINITIONS** section is amended as follows:

The definition of **Employee's Eligibility Date** is replaced with the following:

- **Employee's Eligibility Date** means the later of:
  a) the date of employment;
  b) [the day] after any applicable Waiting Period ends; or
  c) [the day] after any applicable Orientation Period ends.

[Note to Carriers: The rider will require employer-specific text if the employer has requested a date certain such as first of the month.]

- Item b) in the definition of **Hospice** is replaced with the following:

  b) accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

- The following definition of **Orientation Period** is added:

  Orientation Period means a period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).

- [Item a) in the definition of **Small Employer** is replaced with the following:

  a) in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.]

[Note to Carriers: This small employer definition amendment should ONLY be included in policies and certificates that are <u>not</u> issued through the SHOP.]

- The definition of **Waiting Period** is replaced with the following:

  Waiting Period means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.

4. **EMPLOYEE COVERAGE** section is amended as follows:

- The second paragraph of the **Eligible Employees** provision is deleted.

- The **Waiting Period** provision is replaced with the following **The Orientation Period and Waiting Period** provision.

  [**The [Orientation Period and]Waiting Period**
  This Policy has [an Orientation Period and] the following Waiting Periods:

  Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Policyholder by that date, are covered under this Policy from the Effective Date.

  [Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Policyholder by that date, are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

  [Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy from the day after Employees complete [90 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to non-SHOP policies]*

  [Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Policy as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Policyholder.] *[Note to carriers: Applies to -SHOP policies]]*

  [Note to Carriers: This text requires significant adjustment depending on whether the plan is through SHOP or not and the periods elected by the employer.]

5. The **When Dependent Coverage Starts** provision of the **DEPENDENT COVERAGE** section is amended to replace the second and fifth paragraphs with the following:

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the [first day of the calendar month following the] Dependent's Eligibility Date, or

b) the date the Employee becomes insured for Employee coverage.

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:

a) the date the Employee notifies [Carrier] and agrees to make any additional payments, or

b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.

[Note to Carriers: Include this Dependent Coverage section ONLY for SHOP plans. Adjust numbering if this item is not included.]

6. The **COVERED CHARGES** section is amended as follows:

- The **Practitioner's Charges for Surgery** provision is amended to add the following paragraphs:

  Coverage is provided for surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and [Carrier] authorizes coverage for such multi-stage procedure. In addition, [Carrier] will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

  For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

- The **Mammogram Charges** provision is replaced with the following:

  Mammogram Charges
  [Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

  [Carrier] will cover charges for:

  a) one baseline mammogram for a female Covered Person– who is 40 years of age
  b) one mammogram, every year, for a female Covered Person age 40 and older; and

c) a mammogram at the ages and intervals the female Covered Person's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Covered Person who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram [Carrier] will cover charges for:

a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional charges will be covered if one of following conditions are satisfied.

a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Covered Person has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Covered Person's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

[A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.]
[Note to Carriers: Include final paragraph if policy includes limited non-network benefits.]

- The **Diagnosis and Treatment of Autism and Other Developmental Disabilities** provision is amended to replace the third and fourth paragraphs with the following:

  Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

  If a Covered Person's primary diagnosis is autism, in addition to coverage for the therapy services as described above, [Carrier] also cover medically necessary

behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

- The **Vision Benefit** is amended to add the following paragraph:

  [Carrier] covers charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

7. The **EXCLUSIONS** section is amended to replace the exclusion for Weight Reduction of Control with the following:

> ***Weight reduction or control*** including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

8. The **Payment of Premium** provision in the **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** section is replaced with the following:

> **Payment of Premium**
> The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Policyholder’s Anniversary Date following the Employee Open Enrollment Period.

Text to Include on the Compliance and Variability Rider, Exhibit DD, for HMO Plans.

1. The **THERAPY SERVICES** section of the **SCHEDULE OF SERVICES AND SUPPLIES** is amended to replace the text addressing charges for therapy under the Autism and Other Developmental Disabilities Provision with the following text:

Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision 30 visits
Note: The 30-visit limit does not apply to the treatment of autism.

Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) 30 visits
Note: The 30-visit limit does not apply to the treatment of autism.

2. The **DEFINITIONS** section is amended as follows:

The definition of **EMPLOYEE'S ELIGIBILITY DATE** is replaced with the following:

- **EMPLOYEE'S ELIGIBITY DATE.** The later of:
  a) the date of employment;
  b) [the day] after any applicable Waiting Period ends; or
  c) [the day] after any applicable Orientation Period ends.

[Note to Carriers: The rider will require employer-specific text if the employer has requested a date certain such as first of the month.]

- Item b) in the definition of **HOSPICE** is replaced with the following:

  b) accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

- The following definition of **ORIENTATION PERIOD** is added:

  ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).

- [Item a) in the definition of **SMALL EMPLOYER** is replaced with the following:

  b) in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision

that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.]

[Note to Carriers: This small employer definition amendment should ONLY be included in policies and certificates that are <u>not</u> issued through the SHOP.]

- The definition of **WAITING PERIOD** is replaced with the following:

  WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.

3. **EMPLOYEE COVERAGE** section is amended as follows:

- The last paragraph of the **Eligible Employees** provision is deleted.

- The **Waiting Period** provision is replaced with the following **The Orientation Period and Waiting Period** provision.

[**The [Orientation Period and]Waiting Period**
This Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under this Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

[Note to Carriers: This text requires significant adjustment depending on whether the plan is through SHOP or not and the periods elected by the employer.]

4. The **When Dependent Coverage Starts** provision of the **DEPENDENT COVERAGE** section is amended to replace the second and fifth paragraphs with the following:

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the [first day of the calendar month following the] Dependent's Eligibility Date, or

b) the date the Employee becomes insured for Employee coverage.

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:

a) the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.

[Note to Carriers: Include this Dependent Coverage section ONLY for SHOP plans. Adjust numbering if this item is not included.]

5. The **COVERED SERVICES AND SUPPLIES** section is amended as follows:

- Item 22 of the **OUTPATIENT SERVICES** section is expanded to include the following paragraph in the Vision Benefit:

  We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

- Item 23 of the **OUTPATIENT SERVICES** section is replaced with the following Mammogram Coverage provision.

  Mammogram Coverage
  We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the following limitations:

We will cover:

a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:

a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.

a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

- Item 19 of the **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS** section is expanded to include the following:

We also cover surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35

kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

- The **DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES** provision is amended to replace the third and fourth paragraphs with the following:

  Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision.

  If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

6. The **NON-COVERED SERVICES AND SUPPLIES** section is amended to replace the exclusion for Weight Reduction of Control with the following:

Weight reduction or control including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

7. The **PAYMENT OF PREMIUMS – GRACE PERIOD** provision in the **GENERAL PROVISIONS** section is replaced with the following:

PAYMENT OF PREMIUMS - GRACE PERIOD
Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]*. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums from the first day the Contract is in force

[Note to carriers: This amendment applies ONLY to Group Contracts issued to

employers that purchased coverage through the SHOP. It does not apply to Evidence of Coverage documents issued to employees whose employers bought coverage through the SHOP.

If this amendment is not included, re-number the following amendment accordingly.]

8. The **Payment of Premium** provision in the **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** section is replaced with the following:

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].

Text to Include on the Compliance and Variability Rider, Exhibit DD, for HMO-POS Plans.

1. The **LIMITATIONS ON SERVICES AND SUPPLIES** section of the **SCHEDULE OF SERVICES AND SUPPLIES AND COVERED CHARGES** is amended to replace the text addressing charges for therapy under the Autism and Other Developmental Disabilities Provision with the following text:

> Charges for speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision 30 visits
> **Note**: The 30-visit limit does not apply to the treatment of autism.
>
> Charges for physical and occupational per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision (combined benefits) 30 visits
> **Note**: The 30-visit limit does not apply to the treatment of autism.

2. The **DEFINITIONS** section is amended as follows:

The definition of **EMPLOYEE'S ELIGIBILITY DATE** is replaced with the following:

- **EMPLOYEE'S ELIGIBITY DATE.** The later of:
  a) the date of employment;
  b) [the day] after any applicable Waiting Period ends; or
  c) [the day] after any applicable Orientation Period ends.

[Note to Carriers: The rider will require employer-specific text if the employer has requested a date certain such as first of the month.]

- Item b) in the definition of **HOSPICE** is replaced with the following:

  b) accredited for its stated purpose by the Joint Commission, the Community Health Accreditation Program or the Accreditation Commission for Health Care.

- The following definition of **ORIENTATION PERIOD** is added:

  ORIENTATION PERIOD. A period of no longer than one month during which the employer and employee determine whether the employment situation is satisfactory for each party and any necessary orientation and training processes commence. As used in this definition, one month is determined by adding one calendar month and subtracting one calendar day, measured from an Employee's start date in a position that is otherwise eligible for coverage. Refer to 26 C.F.R. 54.9815-2708(c)(iii).

- [Item a) in the definition of **SMALL EMPLOYER** is replaced with the following:

  c) in connection with a Group Health Plan with respect to a Calendar Year and a

Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least one but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least one eligible Employee on the first day of the Plan Year. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.]

[Note to Carriers: This small employer definition amendment should ONLY be included in policies and certificates that are <u>not</u> issued through the SHOP.]

- The definition of **WAITING PERIOD** is replaced with the following:

  WAITING PERIOD. With respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is covered for benefits under the terms of the Group Health Plan. The Waiting Period begins on the first day following the end of the Orientation Period, if any.

3. **EMPLOYEE COVERAGE** section is amended as follows:

- The last paragraph of the **Eligible Employees** provision is deleted.

- The **Waiting Period** provision is replaced with the following **The Orientation Period and Waiting Period** provision.

[**The [Orientation Period and]Waiting Period**
This Contract has [an Orientation Period and] the following Waiting Periods:

Employees in an eligible class on the Effective Date, who [have competed the Orientation Period and who] have completed at least [90 days] [60 days] *[Note to Carriers: Use 60 day maximum for SHOP]*of Full-Time service with the Contractholder by that date, are covered under this Contract from the Effective Date.

[Employees in an eligible class on the Effective Date, who [are completing or have completed the Orientation Period but who] have not completed at least [90 days] of Full-Time service with the Contractholder by that date, are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service.] *[Note to carriers: Omit for SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract from the day after Employees complete [90 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to non-SHOP policies]*

[Employees who enter an eligible class after the Effective Date [who have completed the Orientation Period] are eligible for coverage under this Contract as of the first of the month following [15 or 30 or 45 or 60 days] of Full-Time service with the Contractholder.] *[Note to carriers: Applies to -SHOP policies]]*

[Note to Carriers: This text requires significant adjustment depending on whether the plan is through SHOP or not and the periods elected by the employer.]

4. The **When Dependent Coverage Starts** provision of the **DEPENDENT COVERAGE** section is amended to replace the second and fifth paragraphs with the following:

If the Employee does this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a) the [first day of the calendar month following the] Dependent's Eligibility Date, or

b) the date the Employee becomes insured for Employee coverage.

a. A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:

c) the date the Employee notifies [Carrier] and agrees to make any additional payments, or

d) the [first day of the calendar month following the] Dependent's Eligibility Date for the Newly Acquired Dependent.

[Note to Carriers: Include this Dependent Coverage section ONLY for SHOP plans. Adjust numbering if this item is not included.]

5. The **COVERED SERVICES AND SUPPLIES** section is amended as follows:

- Item 22 of the **OUTPATIENT SERVICES** section is expanded to include the following paragraph in the Vision Benefit:

  We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

- Item 23 of the **OUTPATIENT SERVICES** section is replaced with the following Mammogram Coverage provision.

  Mammogram Coverage
  We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and

the following limitations:

We will cover:

a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:

a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.

a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

- Item 19 of the **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS** section is expanded to include the following:
  We also cover surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

- The **DIAGNOSIS AND TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES** provision is amended to replace the third and fourth paragraphs with the following:

  Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision.

  If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

6. The **Practitioner's Charges for Surgery** section of the **COVERED CHARGES *APPLICABLE TO [NON-NETWORK] BENEFITS*** provision is amended to add the following paragraphs:

  We also cover surgical treatment of morbid obesity for one surgical procedure within a two-year period, measured from the date of the first surgical procedure to treat morbid obesity, unless a multi-stage procedure is planned and We authorize coverage for such multi-stage procedure. In addition, We will cover surgery required as a result of complications that may arise from surgical treatment of morbid obesity.

  For the purpose of this coverage, morbid obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

7. The **COVERED CHARGES WITH SPECIAL LIMITATIONS *APPLICABLE TO [NON-NETWORK] BENEFITS*** provision is amended as follows:

- The **Mammogram Coverage** provision is replaced with the following:

Mammogram Coverage
We cover mammograms provided to a female Member according to the schedule given below. Coverage is provided, subject to all the terms of this Contract, and the

following limitations:

We will cover:

a) one baseline mammogram for a female Member– who is 40 years of age

b) one mammogram, every year, for a female Member age 40 and older; and

c) a mammogram at the ages and intervals the female Member's Practitioner deems to be Medically Necessary and Appropriate with respect to a female Member who is less than 40 years of age and has a family history of breast cancer or other breast risk factors.

In addition, if the conditions listed below are satisfied after a baseline mammogram We will cover:

a) an ultrasound evaluation;
b) a magnetic resonance imaging scan;
c) a three-dimensional mammography; and
d) other additional testing of the breasts.

The above additional services will be covered if one of following conditions are satisfied.

a) The mammogram demonstrates extremely dense breast tissue;
b) The mammogram is abnormal within any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
c) If the female Member has additional risk factors of breast cancer including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or other indications as determined by the female Member's Practitioner.

Please note that mammograms and the additional testing described above when warranted as described above, are included under the Preventive Care provision.

- The **Diagnosis and Treatment of Autism and Other Developmental Disabilities** provision is amended to replace the third and fourth paragraphs with the following:

  Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for the treatment of conditions other than autism. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision. .

If a Member's primary diagnosis is autism, in addition to coverage for the therapy services as described above, We also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

- The **Vision Benefit** is amended to add the following paragraph:

  We cover charges for a one comprehensive low vision evaluation every 5 years. We cover low vision aids such as high-power spectacles, magnifiers and telescopes and medically-necessary follow-up care. As used in this provision, low vision means a significant loss of vision, but not total blindness.

8. The **NON-COVERED SERVICES AND SUPPLIES AND NON-COVERED CHARGES** section is amended to replace the exclusion for Weight Reduction of Control with the following:

> **Weight reduction or control** including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions, except as otherwise provided in the Surgical Treatment of Morbid Obesity section of this Policy and except as provided in the Nutritional Counseling and Food and Food products for Inherited Metabolic Diseases provisions.

9. The **PAYMENT OF PREMIUMS – GRACE PERIOD** provision in the **GENERAL PROVISIONS** section is replaced with the following:

> **PAYMENT OF PREMIUMS - GRACE PERIOD**
> Premiums are to be paid by the Contractholder to [Us] [[XYZ] for remittance to [Us]]. *[Note to carriers: Use the XYZ variable text for SHOP policies where premium must be paid to the SHOP-designated entity. Include the appropriate name at the XYZ variable.]*. They are due on each Premium Due Date stated on the first page of the Contract. The Contractholder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contractholder is liable to pay Premiums from the first day the Contract is in force
>
> *[Note to carriers: This amendment applies ONLY to Group Contracts issued to employers that purchased coverage through the SHOP. It does not apply to Evidence of Coverage documents issued to employees whose employers bought coverage through the SHOP.*
>
> *If this amendment is not included, re-number the following amendment accordingly.]*

10. The **Payment of Premium** provision in the **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** section is replaced with the following:

Payment of Premium
The first month's premium must be paid within the 30-day election period provided above. If the election is made during the Employee Open Enrollment Period the first premium must be paid before coverage takes effect on the Contractholder's Anniversary Date following the Employee Open Enrollment Period.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, [at the times and in the manner specified by [the Carrier]] [and will be remitted by the Employer].