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DEPARTMENT OF BANKING AND INSURANCE
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ADVISORY BULLETIN
15-SEH-02

November 4, 2015

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

From: Ellen DeRosa
Executive Director

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

In September 2015 the Small Employer Health Benefits Program Board (SEH Board) issued a rule proposal proposing amendments to the standard plans B, C, D, HMO and HMO-POS. The SEH Board used the special rulemaking process set forth at N.J.S.A. 17B:27A-51 which allows for a comment period of at least 20 days after which the SEH Board may adopt the amendments. While comments were received during the public hearing and during the period for written comments, the SEH Board did not amend the language in the proposal in response to the comments. At its meeting on October 21, 2015 the SEH Board voted to adopt the amendments as proposed. The notice of adoption has been filed and will appear in an upcoming *New Jersey Register*. The proposal and the adoption may be found on the following website:
http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcrulesadoptions.htm

Recognizing that the process of reissuing policy and contract forms is both lengthy and costly the SEH Board determined it appropriate to give Carriers the option to implement the amendments to inforce policies and contracts by using the Compliance and Variability Rider set forth at N.J.A.C. 11:21 Appendix Exhibit DD. Additionally, the SEH Board appreciates the lead time necessary for carriers to update issue systems for new business and will thus allow carriers to issue the 2015 forms with the Compliance and Variability Rider to new policyholders and new contractholders through the first quarter of 2016. By April 1, 2016, the SEH Board expects carriers will issue 2016 policies and contracts without the use of the Rider.

The text to be included on the Compliance and Variability rider is set forth below. Please note that Carriers must carefully review the text to determine which variable text should be included for each of the policies or contracts to be amended. Refer to the *Note to carriers* for guidance regarding items that may or may not be appropriate to include. Please note that given the

extensive use throughout the forms, the amended term Primary Care Provider (PCP) as used in the HMO and HMO-POS plans is not included in the rider text.

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

Text to include on the Compliance and Variability Rider, Exhibit DD, for Plans B, C and D.

1. The Vision Benefits [and Dental Benefits] section[s] of **SCHEDULE OF INSURANCE** [is] [are] amended to state that benefits apply to Covered Persons through the end of the month in which the Covered Person turns age 19.

2. The **SCHEDULE OF INSURANCE [AND PREMIUM RATES]** is amended to include the following service[s] under the Copayment section:

Telemedicine Visits	[dollar amount not to exceed $50]
E-Visits	[dollar amount not to exceed $50]
Virtual Visits	[dollar amount not to exceed $50]

*[Note to carriers: Include applicable text **only** by carriers offering an insured benefit for telemedicine, e-visits or virtual visits for which cost sharing is required. If included, adjust the numbering below. Include "and premium rates" in the introduction to item 2 when the rider amends the group policy.]*

3. The **PAYMENT OF PREMIUMS- GRACE PERIOD** section of the **GENERAL PROVISIONS** 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: 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. If the premium is not paid by the end of the grace period the Policy will terminate as of the paid-to-date.
[Note to carriers: Include for group policies issued inside the SHOP. If included, adjust the numbering below.]

4. The **PARTICIPATION REQUIREMENTS** section of the **GENERAL PROVISIONS** is replaced with the following:

PARTICIPATION REQUIREMENTS
At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Policyholder;
c. the Employee is covered under Medicare;
d. the Employee is covered under Medicaid or NJ FamilyCare;
e. the Employee is covered under Tricare; or
f. the Employee is covered under another [individual or] group health benefits plan**.**

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.
[Note to carriers: This item applies to all group policies. The Variable text in item f applies to SHOP policies only.]

5. The last paragraph of the **TERM OF THE POLICY – RENEWAL PRIVILEGE** section of the **GENERAL PROVISIONS** is replaced with the following:

[Carrier] has the right to non-renew this Policy on the Policy Anniversary Date subject to 60 days advance written notice to the Policyholder for the following reasons:
a) the Policyholder moves outside the state of New Jersey;
b) [less than [75%] of the Policyholder's eligible full-time Employees are covered by this Policy. If an eligible full-time Employee is not covered by this Policy because:
   1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
   2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Policyholder.
   3. The Employee is covered under Medicare;
   4. The Employee is covered under Medicaid or NJ FamilyCare;
   5. The Employee is covered under TRICARE; or
   6. The Employee is covered under another group or individual health benefits plan;

   [Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.
[Note to carriers: This item applies to SHOP group policies only.]

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

- Item b of the definition of **Dependent** is replaced with the following:

  Dependent child through the end of the month in which he or she attains age 26.
*[Note to carriers: Include **only** by carriers extending termination through the end of the month.]*

- The definition of **Durable Medical Equipment** is expanded to state:
  Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

- The following definition[s] of [E-Visit] [Telemedicine] [Virtual Visit] [is] [are] added.

  E-Visit means a visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Covered Persons who are established patients of the Provider.

  Telemedicine means a telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Covered Persons.

  Virtual Visit means a visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Covered Person and the Provider.

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate term(s) to define.]*

- The definition of **Triggering Event** is amended to add a new item.

  The date of a court order that requires coverage for a Dependent.

7. The **Maximum Out of Pocket** section of the **BENEFIT PROVISION** is replaced with the following:

Maximum Out of Pocket:
The Per Covered Person and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Covered Person, the Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Person Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar][Plan] Year. Once the Per Covered Person Maximum Out of Pocket has been met during a [Calendar][Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] Year.

In the case of coverage which is other than single coverage, for a Covered Person, the per Covered Person Maximum Out of Pocket is the annual maximum dollar amount that a Covered Person must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar][Plan] Year. Once the Per Covered Person Maximum Out of Pocket has been met during a [Calendar][Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered

services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA. If included, adjust the numbering below.]

8. The **Practitioner's Charges for Non-Surgical Care and Treatment** section of the **COVERED CHARGES** provision is amended to add the following sentence[s]:

[We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]
*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate sentence(s) to include. If included, adjust the numbering below.]*

9. The **Durable Medical Equipment** section of the **COVERED CHARGES** provision is amended to add the following sentence:

> Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

10. The first paragraph of the **Dental Benefits** section of the **COVERED CHARGES** provision is replaced with the following:

> Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Insurance and Premium rates, [Carrier] covers the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19 when services are provided by a [Network] provider.

*[Note to carriers: Include **only** by carriers issuing plans with embedded pediatric dental benefits. If included, adjust the numbering below.]*

11. The **Hearing Aids** section of the **COVERED CHARGES** provision is amended to add the following sentence:

> Hearing aids are habilitative devices.

12. The first paragraph of the **Vision Benefit** section of the **COVERED CHARGES** provision is replaced with the following:

> Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule

of Services and Supplies, [Carrier] covers the vision benefits described in this provision for Covered Persons through the end of the month in which the Covered Person turns age 19. [Carrier] covers one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period.

13. The ***Telephone*** consultations item of **EXCLUSIONS** provision replaced with the following:

Telephone consultations except as stated in the Practitioner's Charges for Non-Surgical Care and Treatment provision.

*[Note to carriers: Include **only** by carriers that added text to the Practitioner's Charges for Non-Surgical Care and Treatment provision.]*

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

1. The Vision Benefits [and Dental Benefits] section[s] of **SCHEDULE OF SERVICES AND SUPPLIES** [is] [are] amended to state that benefits apply to Members through the end of the month in which the Member turns age 19.

2. The **SCHEDULE OF SERVICES AND SUPPLIES** is amended to include the following service[s] under the Copayment section:

Telemedicine Visits	[dollar amount not to exceed $50]
E-Visits	[dollar amount not to exceed $50]
Virtual Visits	[dollar amount not to exceed $50]

*[Note to carriers: Include applicable text **only** by carriers offering an insured benefit for telemedicine, e-visits or virtual visits for which cost sharing is required. If included, adjust the numbering below. Include "and premium rates" in the introduction to item 2 when the rider amends the group policy.]*

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

- Item b of the definition of **DEPENDENT** is replaced with the following:

Dependent child through the end of the month in which he or she attains age 26.

*[Note to carriers: Include **only** by carriers extending termination through the end of the month.]*

- The definition of **DURABLE MEDICAL EQUIPMENT** is expanded to state:
  Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

- The following definition[s] of [E-Visit] [Telemedicine] [Virtual Visit] [is] [are] added.

  E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Members who are established patients of the Provider.

  TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Members.

  VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Member and the Provider.

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate term(s) to define.]*

- The definition of **TRIGGERING EVENT** is amended to add a new item.

  The date of a court order that requires coverage for a Dependent.

4. The **Maximum Out of Pocket** section of the **COVERAGE PROVISION** is replaced with the following:

Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance and

Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA. If included, adjust the numbering below.]

5. The **Office Visits** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence[s]:

[We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate sentence(s) to include. If included, adjust the numbering below.]*

6. The **Durable Medical Equipment** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence:

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

7. The **Hearing Aids** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence:

Hearing aids are habilitative devices.

8. The first paragraph of the **Vision Benefit** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to replaces the first paragraph with the following:

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

9. The heading and third paragraph of the **DENTAL CARE AND TREATMENT** provision are replaced with the following:

[Dental Benefits available to [Members] through the end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

*[Note to carriers: Include **only** by carriers issuing plans with embedded pediatric dental benefits. If included, adjust the numbering below.]*

10. The ***Telephone*** consultations item of **NONCOVERED SERVICES AND SUPPLIES** provision replaced with the following:

[Telephone consultations. [except as stated in the Outpatient Services provision].]

*[Note to carriers: Include **only** by carriers that added text to the Practitioner's Charges for Non-Surgical Care and Treatment provision.]*

11. The **PARTICIPATION REQUIREMENTS** section of the **GENERAL PROVISIONS** is replaced with the following:

PARTICIPATION REQUIREMENTS

At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Contract because:

a) the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b) the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder;
c) the Employee is covered under Medicare;
d) the Employee is covered under Medicaid or NJ FamilyCare;
e) the Employee is covered under Tricare; or
f) the Employee is covered under another group [or individual] health benefits plan**.**

[Carrier] will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

[Note to carriers: This item applies to all group contracts. The Variable text in item f applies to SHOP contracts only.]

12. The **PAYMENT OF PREMIUMS- GRACE PERIOD** section of the **GENERAL PROVISIONS** is replaced with the following:

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Contractholder to [Carrier] [[XYZ] for remittance to [Carrier]]. *[Note to carriers: 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 Contract. The Contractholder 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. If the premium is not paid by the end of the

grace period the Policy will terminate as of the paid-to-date.
[Note to carriers: Include for group contracts issued inside the SHOP. If included, adjust the numbering below.]

5. The last paragraph of the **TERM OF THE POLICY – RENEWAL PRIVILEGE** section of the **GENERAL PROVISIONS** is replaced with the following:

We have the right to non-renew this Contract on the Contract Anniversary Date subject to 60 days advance written notice to the Contractholder for the following reasons:
a) the Contractholder moves outside the state of New Jersey;
b) [less than [75%] of the Contractholder's eligible [full-time Employees are covered by this Contract. If an eligible a full-time Employee is not covered by this Contract because:
    1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
    2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder.
    3. The Employee is covered under Medicare;
    4. The Employee is covered under Medicaid or NJ FamilyCare;
    5. The Employee is covered under TRICARE; or
    6. The Employee is covered under another group or individual health benefits plan,
    7. [Carrier] will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;]

[Note to carriers: This item applies to SHOP group policies only.]

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

1. The **SCHEDULE OF SERVICES AND SUPPLIES** is amended to include the following service[s] under the Copayment section:

[Telemedicine Visits	[$15] Copayment / visit	N/A]
[E-Visits	[$15] Copayment / visit	N/A]
[Virtual Visits	[$15] Copayment / visit	N/A]

*[Note to carriers: Include applicable text **only** by carriers offering an insured benefit for telemedicine, e-visits or virtual visits for which cost sharing is required. If included, adjust the numbering below. Include "and premium rates" in the introduction to item 2 when the rider amends the group policy.]*

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

- Item b of the definition of **DEPENDENT** is replaced with the following:

Dependent child through the end of the month in which he or she attains age 26.
*[Note to carriers: Include **only** by carriers extending termination through the end of the month.]*

- The definition of **DURABLE MEDICAL EQUIPMENT** is expanded to state:
  Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

- The following definition[s] of [E-Visit] [Telemedicine] [Virtual Visit] [is] [are] added.
  E-VISIT. A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and Members who are established patients of the Provider.

  TELEMEDICINE. A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services for Members.

  VIRTUAL VISIT. A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the Member and the Provider.

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate term(s) to define.]*

- The definition of **TRIGGERING EVENT** is amended to add a new item.

  The date of a court order that requires coverage for a Dependent.

3. The **Maximum Out of Pocket** section of the **COVERAGE PROVISION** is replaced with the following:

Maximum Out of Pocket:
The Per Member and Per Covered Family Maximum Out of Pocket amounts are shown in the Schedule.

In the case of single coverage, for a Member, the Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Member Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Member Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayments will be required for such Member for the rest of the [Calendar] [Plan] Year.

In the case coverage which is other than single coverage, for a Member, the per Member Maximum Out of Pocket is the annual maximum dollar amount that a Member must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all

covered services and supplies in a [Calendar] [Plan]Year. Once the Per Member Maximum Out of Pocket has been met during a Calendar Year, no further Deductible or Coinsurance or Copayments will be required for such Covered Person for the rest of the [Calendar][Plan] Year.

In the case of coverage which is other than single coverage, for a Covered Family, the Maximum Out of Pocket is the annual maximum dollar amount that members of a covered family must pay as per Covered Family Cash Deductible *plus* Coinsurance and Copayments for all covered services and supplies in a [Calendar] [Plan] Year. Once the Per Covered Family Maximum Out of Pocket has been met during a [Calendar] [Plan] Year, no further Deductible or Coinsurance or Copayment will be required for members of the covered family for the rest of the [Calendar] [Plan] Year.]

[Note to carriers: Use the above text if the plan is issued as a high deductible health plan that could be used in conjunction with an HSA. If included, adjust the numbering below.]

4. The **Office Visits** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision is amended to add the following sentence[s]:

[We also cover Telemedicine charges.] [We also cover E-Visit charges.] [We also cover Virtual Visit charges.]

*[Note to carriers: Include **only** by carriers offering insured (as opposed to value-added) benefits for telemedicine, e-visits or virtual visits whether or not cost sharing is required. Carriers select the appropriate sentence(s) to include. If included, adjust the numbering below.]*

5. The **Durable Medical Equipment** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision and the **Durable Medical Equipment** item of the **COVERED CHARGES** provision are amended to add the following sentence:

Items such as walkers, wheelchairs and hearing aids are examples of durable medical equipment that are also habilitative devices.

6. The **Hearing Aids** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision and the **Hearing Aids** section of the **COVERED CHARGES** provision are amended to add the following sentence:

Hearing aids are habilitative devices.

7. The first paragraph of the **Vision Benefit** item of the **OUTPATIENT SERVICES** section of the **COVERED SERVICES AND SUPPLIES** provision and the **Vision Benefit** item of the **COVERED CHARGES** provision are amended to replaces the first paragraph with the following:

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the vision benefits described in this provision for Members through end of the month in which the Member turns age 19. We cover one

comprehensive eye examination by a [Network] ophthalmologist or optometrist in a 12 month period. We cover one pair of lenses, for glasses or contact lenses, in a 12 month period. We cover one pair of frames in a 12 month period. Standard frames refers to frames that are not designer frames such as Coach, Burberry, Prada and other designers.

8. The heading and third paragraph of the **DENTAL CARE AND TREATMENT** provision are replaced with the following:

[Dental Benefits available to [Members] through the end of the month in which the Member turns age 19

Subject to the applicable Deductible, Coinsurance or Copayments shown on the Schedule of Services and Supplies, We cover the diagnostic, preventive, restorative, endodontic, periodontal, prosthodontic, oral and maxillofacial surgical, orthodontic and certain adjunctive services in the dental benefit package as described in this provision for covered persons through the end of the month in which the Member turns age 19.

*[Note to carriers: Include **only** by carriers issuing plans with embedded pediatric dental benefits. If included, adjust the numbering below.]*

9. The ***Telephone*** consultations item of **NONCOVERED SERVICES AND SUPPLIES** provision replaced with the following:

[Telephone consultations. [except as stated in the Outpatient Services provision].]

*[Note to carriers: Include **only** by carriers that added text to the Practitioner's Charges for Non-Surgical Care and Treatment provision.]*

10. The **PARTICIPATION REQUIREMENTS** section of the **GENERAL PROVISIONS** is replaced with the following:

PARTICIPATION REQUIREMENTS

At least [75%] of the Employees eligible for insurance must be enrolled for coverage. If an Employee eligible for insurance is not covered by this Contract because:

a) the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
b) the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder;
c) the Employee is covered under Medicare;
d) the Employee is covered under Medicaid or NJ FamilyCare;
e) the Employee is covered under Tricare; or
f) the Employee is covered under another group [or individual] health benefits plan**.**

[Carrier] will count this person as being covered by this Contract for the purposes of satisfying participation requirements.

[Note to carriers: This item applies to all group contracts. The Variable text in item f applies to SHOP contracts only.]

11. The **PAYMENT OF PREMIUMS- GRACE PERIOD** section of the **GENERAL PROVISIONS** is replaced with the following:

PAYMENT OF PREMIUMS - GRACE PERIOD

Premiums are to be paid by the Contractholder to [Carrier] [[XYZ] for remittance to [Carrier]]. *[Note to carriers: 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 Contract. The Contractholder 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. If the premium is not paid by the end of the grace period the Policy will terminate as of the paid-to-date.

[Note to carriers: Include for group contracts issued inside the SHOP. If included, adjust the numbering below.]

12. The last paragraph of the **TERM OF THE POLICY – RENEWAL PRIVILEGE** section of the **GENERAL PROVISIONS** is replaced with the following:

We have the right to non-renew this Contract on the Contract Anniversary Date subject to 60 days advance written notice to the Contractholder for the following reasons:

a) the Contractholder moves outside the state of New Jersey;
b) [less than [75%] of the Contractholder's eligible [full-time Employees are covered by this Contract. If an eligible a full-time Employee is not covered by this Contract because:
    1. the Employee is covered as a Dependent under a spouse's coverage, other than individual coverage;
    2. the Employee is covered under any fully-insured Health Benefits Plan [issued by the same carrier] offered by the Contractholder.
    3. The Employee is covered under Medicare;
    4. The Employee is covered under Medicaid or NJ FamilyCare;
    5. The Employee is covered under TRICARE; or
    6. The Employee is covered under another group or individual health benefits plan,
    7. [Carrier] will count that Employee as being covered by this Contract for purposes of satisfying participation requirements;]

[Note to carriers: This item applies to SHOP group policies only.]