



**State of New Jersey**  
DEPARTMENT OF BANKING AND INSURANCE  
INDIVIDUAL HEALTH COVERAGE PROGRAM  
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**ADVISORY BULLETIN**  
**14-IHC-01**

November 17, 2014

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

From: Ellen DeRosa   
Executive Director

**Re: Adopted Amendments to Standard Plans A/50, B, C, D and HMO**

In October 2014 the Individual Health Coverage Program Board (IHC Board) issued a rule proposal proposing amendments to the standard plans A/50, B, C, D and HMO. The IHC Board used the special rulemaking process set forth at N.J.S.A. 17B:27A-16.1 which allows for a comment period of at least 20 days after which the IHC Board may adopt the amendments. No comments were received during the public hearing on the amendments or during the period for written comments. At its meeting on November 12, 2014 the IHC Board voted to adopt the amendments as proposed. The notice of adoption is expected to appear in the December 15, 2014 *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](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 IHC Board determined it appropriate to give Carriers the option to implement the amendments to enforce policies and contracts by using the Compliance and Variability Rider set forth at N.J.A.C. 11:20 Appendix Exhibit D. Additionally, the IHC Board appreciates the lead time necessary for carriers to update issue systems for new business and will thus allow carriers to issue the 2014 forms with the Compliance and Variability Rider to new policyholders and new contractholders through the first quarter of 2015. By the second quarter of 2015, the IHC Board expects carriers will issue 2015 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.

Please contact me with any questions at [ellen.derosa@dobi.state.nj.us](mailto:ellen.derosa@dobi.state.nj.us).

**Text to include on the Compliance and Variability Rider, Exhibit D, for Plans A/50 – D.**

[1. The **SCHEDULE OF INSURANCE** for the Catastrophic plan is amended as follows:

- The Per Covered Person Cash Deductible is increased to \$6,600.
- The Per Covered Family Cash Deductible is increased to \$13,200.
- The Per Covered Person Maximum Out of Pocket is increased to \$6,600.
- The Per Covered Family Maximum Out of Pocket is increased to \$13,200.]

*[Note to carriers: Include **only** for the Catastrophic Plan. If included, adjust the numbering below.]*

1. The **Payment Limits** section of **SCHEDULE OF INSURANCE** is amended to replace the section that specifies the benefits for physical, occupational and speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision with the following:

Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision.

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. (limit applies separately to each therapy and is in addition to the therapy visits listed above) 30 visits

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

- The definition of Anniversary Date is deleted.
- The definition of Annual Open Enrollment Period is replaced with the following:

**Annual open enrollment period** means the designated period of time each year during which

- a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
  - b) individuals who already have coverage may replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.
- Item “b” of the definition of Hospice is replaced with the following:
    - b) it is 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 Renewal Date is added.

**Renewal Date** means January 1 of the year immediately following the Effective Date of this Policy and each succeeding January 1 thereafter.

3. The **Mammogram Charges** section of the **COVERED CHARGES** provision is replaced with the following:

**Mammogram Charges**

We cover 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:

We 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) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman’s Practitioner.

In addition, if the conditions listed below are satisfied after a baseline mammogram We 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 is 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 the variable text for plans that provide non-network benefits]*

4. The third and fourth paragraphs of the **Diagnosis and Treatment of Autism and Other Developmental Disabilities** section of the **COVERED CHARGES** provision are replaced with the following:

Coverage for occupational therapy is limited to 30 visits per Calendar Year for treatment of conditions other than autism. Coverage for physical therapy is limited to 30 visits per Calendar Year for treatment of conditions other than autism. Coverage for speech therapy is limited to 30 visits per Calendar Year for 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, 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.

5. The **Vision Benefit** in the **COVERED CHARGES** provision 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.

6. The **TERM OF THE POLICY - RENEWAL PRIVILEGE – TERMINATION** provision is replaced with the following:

#### **RENEWAL PRIVILEGE – TERMINATION**

All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

The Policyholder may renew this Policy for a term of one (1) year, on the first and each subsequent Renewal Date. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Policy on the Renewal Date following written notice to the Policyholder for the following reasons:

- a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
- b) subject 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act uniformly without regard to any Health Status-Related Factor of Covered Persons or persons who may become eligible for coverage;

- c) subject 90 days advance written notice, the Board terminates a standard plan or a standard plan option[; or]
- d) [with respect to coverage issued through the marketplace, decertification of the plan]. The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to marketplace requirements, if any.  
*[Note to Carriers: Omit item d for policies not issued through the Marketplace.]*

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Policy will end as described in the Grace Period provision.

Termination by Request - If You want to replace this Policy with another individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Policy will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Policy and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which premiums have been paid. Then the Policy will end on the date requested.

This Policy will be renewed automatically each year on the Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

- a) You have failed to pay premiums in accordance with the terms of the Policy, or We have not received timely premium payments; (Coverage will end as described in the Grace Period provision.)
- b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Policy; (Coverage will end [as of the effective date][immediately].) *[Note to carriers: Select appropriate text to include on the rider.]*
- c) with respect to a Covered Person other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
- d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
- e) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Covered Person is no longer eligible for an exemption, or until the end of the plan year in which the Covered Person attains age 30, whichever occurs first.

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

1. The **Limitation on Services and Supplies** section of **SCHEDULE OF SERVICES AND SUPPLIES** is amended to replace the section that specifies the benefits for physical, occupational and speech therapy provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision with the following :

Charges for physical, occupational and speech therapy per Calendar Year provided under the Diagnosis and Treatment of Autism and Other Developmental Disabilities Provision. 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. (limit applies separately to each therapy and is in addition to the therapy visits listed above) 30 visits

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

- The definition of ANNIVERSARY DATE is deleted.
- The definition of ANNUAL OPEN ENROLLMENT PERIOD is replaced with the following:

**ANNUAL OPEN ENROLLMENT PERIOD.** The designated period of time each year during which

- a) individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and
  - b) individuals who already have coverage may replace current coverage with a different standard health benefits plans or standard health benefits plan with rider.
- Item “b” of the definition of HOSPICE is replaced with the following:
    - b) it is 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 RENEWAL DATE is added.

**RENEWAL DATE.** January 1 of the year immediately following the Effective Date of this Policy and each succeeding January 1 thereafter.

3. Item 21 of the **COVERED SERVICES AND SUPPLIES** provision is replaced with the following:

21) **Mammogram Screening** We will provide coverage for:

- 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) in the case of a woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed medically necessary by the woman’s Practitioner.

- d) In addition, if the conditions listed below are satisfied after a baseline mammogram  
We will cover charges for:
- e) an ultrasound evaluation;
- f) a magnetic resonance imaging scan;
- g) a three-dimensional mammography; and
- h) other additional testing of the breasts.

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

4. Item 24 of the **COVERED SERVICES AND SUPPLIES** provision is amended to include the following paragraph to 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.

5. The **TERM OF THE CONTRACT – RENEWAL PRIVILEGE – TERMINATION** provision is replaced with the following:

#### **RENEWAL PRIVILEGE – TERMINATION**

All Contract Years and Contract Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:01 am. Eastern Standard Time.

The Contractholder may renew this Contract for a term of one (1) year, on the first and each subsequent Renewal Date. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's **Premium Rates** section and to the provisions stated below.

We have the right to non-renew this Contract on the Renewal Date following written notice to the Contractholder for the following reasons:

- a) subject to 180 days advance written notice, We cease to do business in the individual health benefits market;
- b) subject to 90 days advance written notice, We cease offering and non-renew a particular type of Health Benefits Plan in the individual market provided We act

uniformly without regard to any Health Status-Related Factor of Members or persons who may become eligible for coverage;

c) subject to 90 days advance written notice the Board terminates a standard plan or a standard plan option[;or]

d) [with respect to coverage issued through the marketplace, decertification of the plan.]

The advance written notice for non-renewal for the reasons stated in items a, b and c above shall comply with the requirements of N.J.A.C. 11:20-18. Any notice provided in the event of item [d] above will be subject to marketplace requirements, if any.

*[Note to Carriers: Omit item d for policies not issued through the Marketplace.]*

During or at End of Grace Period - Failure to Pay Premiums: If any premium is not paid by the end of its grace period, the Contract will end as described in the Grace Period provision.

Termination by Request - If You want to replace this Contract with another individual Health Benefits Plan, You must give us notice of the replacement within 30 days after the effective date of the new Plan. This Contract will end as of 12:01 a.m. on the effective date of the new Plan and any unearned premium will be refunded. If You want to end this Contract and do not want to replace it with another Plan, You may write to Us, in advance, to ask that the Contract be terminated at the end of any period for which premiums have been paid. Then the Contract will end on the date requested.

This Contract will be renewed automatically each year on the Renewal Date, unless coverage is terminated on or before the Renewal Date due to one of the following circumstances:

- a) You have failed to pay premiums in accordance with the terms of the Contract, or We have not received timely premium payments; ([Coverage will end as described in the Grace Period provision.]
- b) You have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the Contract; (Coverage will end [as of the effective date][immediately].) *[Note to carriers: Select appropriate text to include on the rider.]*
- c) with respect to a Member other than a Dependent, termination of eligibility if You are no longer a Resident, (We will give You at least 30 days written notice that coverage will end.)
- d) You become covered under another individual Health Benefits Plan; (Coverage will end at 12:01 a.m. on the date the individual Health Benefits Plan takes effect, provided We receive notice of the replacement within 30 days after the effective date of the new plan.)
- e) [You no longer reside, live or work in the Service Area, or in an area for which We are authorized to do business, provided that coverage is terminated uniformly without regard to any Health Status-Related Factor of Members.]
- f) with respect to a catastrophic plan, the date of a marketplace redetermination of exemption eligibility that finds the Member is no longer eligible for an exemption, or until the end of the plan year in which the Member attains age 30, whichever occurs first.