INSURANCE
NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD
Small Employer Health Benefits Program

Readoption with Amendments: N.J.A.C. 11:21-1 through 7, 8, 10, 17, 18, 23 and Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, BB Parts 1 and 2, CC, DD, II and KK.

Adopted Repeals: N.J.A.C. 11:21 5.1, 6.3, 17.4 and Appendix Exhibits I, K, L, M, Q, JJ and Z.

Adopted New Rules: N.J.A.C. 11:21-1.6, 7.15, 23, and Appendix Exhibit K

Proposed: November 3, 2003 at 35 N.J.R. 5011(a)

Adopted: February 18, 2004 by the New Jersey Small Employer Health Benefits Program Board, Wardell Sanders, Executive Director.

Filed: February 19, 2004 as R. 2004 d. 107, with substantive and technical changes not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3).

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

Effective Date: February 19, 2004, Readoption; March 15, 2004, Amendments, Repeals and New Rules

Operative Date: October 1, 2004 as to the amendments to N.J.A.C. 11:21-3 and 4 and Appendix Exhibits A, F, G, V, W, Y, BB, HH and II and the repeal of and new Appendix Exhibit K.

Expiration Date:

Summary of Hearing Officer Recommendations and Agency Responses:

The New Jersey Small Employer Health Benefits (SEH) Program Board held a hearing on Wednesday, December 3, 2003 at 1:00 P.M. at the Department of Banking and Insurance, Room 218, 20 West State Street, Trenton, New Jersey to receive testimony with respect to the proposed amendments, repeals and new rules to the standard health benefits plan set forth in N.J.A.C. 11:21 as Appendix Exhibits A, F, G, H, K, N, O, T, V, W, Y, DD, HH and II. Ellen DeRosa served as hearing officer. No testimony was provided during the hearing. The hearing officer made no

recommendations regarding the proposed amendments, repeals and new rules to the standard health benefits plan set forth in N.J.A.C. 11:21 as Appendix Exhibits A, F, G, H, K, N, O, T, V, W, Y, DD, HH and II. The hearing record may be reviewed by contacting Ellen deRosa, Deputy Executive Director, New jersey Small Employer health benefits Program Board, P.O. Box 325, Trenton, NJ 08625-0325.

The Commissioner of Banking and Insurance held a hearing on the Plan of Operations, N.J.A.C. 11:21, on January 22, 2004 and approved the Plan of Operations on January 23, 2004.

Summary of Public Comments and Agency Responses:

Comments to the proposal readoption published at 35 N.J.R 5011(a) were received from the following individuals: Lesley Schwartzman, Steven and Cynthia Bayhem and Maryellen Miller; and from the following carriers: Aetna Health, Inc. and Oxford Health Plans.

COMMENT 1: Three Commenters expressed disappointment that the small employer health benefit plans, as proposed, did not include coverage for invitro fertilization (IVF). Two commenters stated they felt they deserved the "same coverage as those who are lucky enough to have their coverage through a large group." One commenter noted she was given excellent odds with IVF.

RESPONSE: The comments offered by the two commenters were substantially the same as comments provided in response to the Board's rule proposal at 34 N.J.R. 648(a). The Board summarized those comments in COMMENT 1 and provided an extensive response which appears at 35 N.J.R. 5011(a). Neither of the commenters who commented in response to the current proposed readoption offered information that had

not been considered in formulating a response to the prior comments, nor did the commenters challenge or refute the information the Board included in its response. Thus, while the Board sympathizes with those persons who have been diagnosed as being infertile and who have been advised that in vitro fertilization could lead to successful conception, the Board maintains its prior position and declines the request to include coverage for in vitro fertilization in the standard plans.

COMMENT 2: One Commenter requested that the Premium Paid section of item 15 of the Employer Application as set forth as Appendix Exhibit N be amended to make the quarterly payment mode optional. The commenter indicated she was unaware of any requirement that carriers allow quarterly premium payments.

RESPONSE: The Board agrees with the commenter and has included brackets around the quarterly premium payment mode.

COMMENT 3: One commenter questioned whether the Certification of Compliance should require carriers to provide information regarding purchasing alliances given the fact that the Certification of Compliance requires carriers to address whether coverage is issued through a Multiple Employer Trust (MET).

RESPONSE: The Board notes that MET coverage involves the use of a Trust, which may be an out-of State trust. Since the policyholder for an MET plan is the Trustee of the Trust, the Board believes it is important to require carriers to identify any Trusts used in issuing coverage to small employers in New Jersey. Purchasing alliances allow employers to negotiate with carriers for rate discounts and do not have any impact on the policy or certificate forms the carrier issues to small employers. Since the policy is not issued to the purchasing alliance but rather, policies continue to be issued to each

small employer, the Board does not believe there is any need to require carriers to provide policy form specific information regarding purchasing alliances. The Board notes that carriers that wish to provide discounted rates to employers that are part of a purchasing alliance are required to file rating information with the Department of Banking and Insurance. In addition, the purchasing alliance must file with the Department of Banking and Insurance. The Board is not making a change in response to this comment.

COMMENT 4: One commenter noted that the second sentence in item 5 of the Plans A through E section of the Explanation of Brackets, Exhibit K, refers to "maximum out of pocket Cap."

RESPONSE: The Board thanks the commenter for noting that the word "Cap" was incorrectly included. The text has been revised to refer to "maximum out of pocket."

COMMENT 5: One commenter noted that item 33 of the Plans A through E section of the Explanation of Brackets, Exhibit K, states " rather that in use the personal…"

RESPONSE: The Board thanks the commenter for noting the error. The Board has revised the sentence to state "rather than use the personal…"

COMMENT 6: One commenter noted that the Explanation of Brackets, Exhibit K, includes two sections that address HMO coverage and asked if one was intended to address the HMO-POS coverage.

RESPONSE: The Board thanks the commenter for noting the error. The second section should have been identified as addressing HMO-POS coverage and has been labeled as such in the adoption.

COMMENT 7: With respect to the Employer Application, set forth at Exhibit N, one commenter stated that carriers should be permitted to "add a legal section to the electronic application process regarding the legal significance and importance of an electronic signature."

RESPONSE: The Employer Application, as proposed, allows carriers to use the document to accept applications electronically, and the Board refers the commenter to item 8 of the Employer Application section of the Explanation of Brackets. The Board believes that applicable New Jersey law will determine the acceptability of the electronic application process, including the electronic signature. The Board refers the commenter to P.L. 2001, c. 116 which created the Uniform Electronic Transactions Act. The Board does not believe the application is the appropriate place to attempt to inform applicants of the legal significance of a signature, whether electronic or otherwise. If a carrier wishes to provide information regarding electronic signatures as part of the carrier's electronic process rather than as part of the standard application form, a carrier may do so.

COMMENT 8: One commenter asked for clarification of the Maximum Out of Pocket (MOOP) amount that will appear in the member's schedule page. The commenter asked if the MOOP amount should be the sum of the deductible and the MOOP and gave an example of a $250.00 deductible and a $2,000 MOOP and asked if the MOOP amount should be listed as $2,250. The commenter also asked if such addition is only required for indemnity products but not for products offered though a selective contracting arrangement.

RESPONSE: The Board refers the commenter to the Maximum Out of Pocket section of the schedule page as contained in the proposed standard plans. The second

sentence of the section states “All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket.” Thus, the Maximum Out of Pocket amount already includes the amount of the deductible. The Maximum Out of Pocket amount includes not just the deductible, but also all amounts the member pays as copayment and coinsurance. The same holds true whether the plan is issued as an indemnity plan or as a plan through a selective contracting arrangement. In the example the commenter offered, the maximum out of pocket amount would be specified as $2,000.

COMMENT 9: One commenter noted that the policy and certificate forms contain the same information except for a few pages specific to the employer. The commenter asked if a carrier can simply add those few pages to the certificate in order to simplify administration.

RESPONSE: The Board notes that the standard plans, as they have existed since 1994 and as proposed in the proposed readoption, require carriers to issue a policy/contract to the employer and a certificate/evidence of coverage for each covered employee. While the Board appreciates the administrative simplification that might be accomplished by using what many carriers refer to as a “wrapper” document to specify provisions that are peculiar to the employer contract, the Board recognizes that the policy forms exhibits, as proposed, do not lend themselves to such an approach. The Board believes that allowing the approach the commenter requested would require the Board to create new exhibits that contain those provisions that would be added to a certificate form to create a policy form. The Board understands from the commenter that such an approach could simplify carrier administration. The commenter provided no information

regarding how employers who would be issued such a document might be impacted. The commenter did not address how the provisions that are peculiar to the employers are linked to the certificate form such that a legal contract is created. The Board is not creating any new exhibits at this time to accomplish the change requested by the commenter. The Board welcomes additional information from the commenter and others that might be interested in using the approach requested by the commenter.

COMMENT 10: One commenter applauded the Board for the proposed change that limits waiting period changes to the plan anniversary.

RESPONSE: The Board thanks the commenter.

COMMENT 11: One commenter applauded the Board's change from coinsured charge limit and coinsurance cap to Maximum Out of Pocket. The commenter said the change will greatly aid the member's understanding of their financial responsibilities.

RESPONSE: The Board thanks the commenter.

COMMENT 12: One commenter questioned whether the per Covered Family Deductible as it appears on the Schedule page may be expressed as an amount rather than the three times text that is illustrated on the specimen schedule pages.

RESPONSE: The Board intended that carriers would specify the actual dollar amount of the per covered family deductible on the Schedule page and thus expressed the value as a dollar amount. Since the Board is allowing carriers significant flexibility to determine amounts for the cash deductible, the Board could not illustrate every possible family deductible amount and thus included the rule to calculate the amount.

COMMENT 13: One commenter observed that once a person satisfied the Maximum Out of Pocket, no further copayments are required. The commenter stated that

a provider may nevertheless continue to charge the member and suggested that the member may submit a claim to the carrier for reimbursement of the copayment. The commenter suggested that such process be included in the policy forms.

RESPONSE: The Board notes that the remedy the commenter suggested for the recovery of a copayment is acceptable in that it achieves the desired result of the member not being responsible for copayments once the Maximum Out of Pocket has been reached. The Board recognizes that such a practice would be one carrier's method to address the fact that the member has no further financial obligation for copayments during that calendar year. Such an administrative practice would perhaps better be stated in a member guidelines document rather than the certificate. Other carriers may remedy an inappropriate collection of a copayment in another manner and other carriers may institute a policy whereby the copayment ceases to be collected by the provider. Thus, it would not be appropriate to attempt to address an administrative practice in the certificate. No change is being made in response to this comment.

COMMENT 14: One commenter asked why Plan B has a plan specific schedule page given the fact that Plan B, as proposed, no longer imposes a $1 million lifetime maximum benefit.

RESPONSE: The Board agrees that the $1 million lifetime maximum was an area in which Plan B previously differed from Plans C through E. Plan B continues to differ from Plans C through E in that it includes a hospital confinement copayment requirement, where the copayment is in addition to the deductible and coinsurance. Thus, Plan B continues to necessitate a distinct schedule page.

COMMENT 15: One commenter observed that the Termination of the Policy-Renewal Privilege Provision section failed to include the new circumstances for which participation credit is granted.

RESPONSE: The Board thanks the commenter for noting this omission. The Board is amending the provision to include coverage under Medicare and coverage under another group plan as circumstances for participation credit, as required by P.L. 2001, c. 346.

COMMENT 16: One commenter asked whether the participation requirements provision in the policy forms should address participation in a purchasing alliance.

RESPONSE 16: The coverage issued to employers participating in a purchasing alliance is subject to no different participation requirement than coverage issued to an employer who is not a member of a purchasing alliance. Therefore, no change is being made in response to this comment.

COMMENT 17: One commenter asked that the termination language in the "Term of the Policy Renewal Privilege" provision which allows a policyholder to request policy termination by giving written notice in advance be revised to specify how far in advance the termination request must be given and suggested that the period be 72 hours or five business days. The commenter wished to avoid receiving a faxed notice of termination hours before the requested termination date.

RESPONSE: The Board notes that the termination language addresses a very narrow window of opportunity for an employer to request termination of coverage, namely the end of the period for which premiums have been paid or a date during the 31-day grace period. The Board further notes that employers can be held liable for premium

for the time coverage stays in force during the grace period. The termination language was intended to give employers the ability to prospectively inform a carrier that coverage is to terminate and thus avoid premium responsibility from that date forward. If an employer is transferring coverage from one carrier to another, the employer will want to avoid premium liability to the old carrier once the new carrier's coverage is effective. Requiring that notice be given five business days in advance could place the employer in a difficult financial position. If the employer receives notice on Tuesday that the new coverage is effective, the commenter's suggestion would allow the prior carrier to count five business days from Tuesday bringing the earliest termination date to the following Tuesday. The employer would thus be liable for premium for that additional week period which the Board believes to be an unacceptable consequence to the employer. The Board notes that the provision, as proposed, states notice must be provided in advance. Therefore, notice given and received on Tuesday requesting immediate termination should result in termination no later than the next day since coverage has already been in effect on the date the notice is received. The earliest advance date would be the following day. No change is being made in response to the comment.

COMMENT 18: One commenter asked that the definition of "Developmental Disability" be amended to state that the limitation described in item d should be as determined by an appropriately licensed medical provider.

RESPONSE: The Board questions whether a medical provider would be in a position to evaluate all of the items listed in item d which states: "results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for

independent living; economic self-sufficiency." The Board believes that carriers will consider information provided by medical providers as well as by social workers and other professionals to determine whether the criteria specified in item d have been satisfied. A provision that would consider only the determination of a person's own medical provider would not allow for the consideration of other pertinent and vital information. No change is being made in response to the comment.

COMMENT 19: One commenter suggested that the caption for the "Network Maximum Out of Pocket" section should read "Combined or Shared Network and Non-Network."

RESPONSE: The Board notes that the dollar amount of the Maximum Out of Pocket in the instance where it applies to both network and non-network services is in fact the Network Maximum Out of Pocket and is not some other amount. Rather than introduce a new term to refer to an amount that already exists as Network Maximum Out of Pocket, the Board chose to use the already-existing term. Using the same term will likely assist purchasers when comparing plans of one carrier to another. For example, assume a Network Maximum Out of Pocket of $2,000. For one carrier, that $2,000 can be met only with network charges. For another carrier, it can be met with both network and non-network charges. The $2,000 amount with the second carrier may be more attractive since non-network charges are included whereas they are not with the first carrier.

COMMENT 20: One commenter asked that the Home Health Care text which refers to a visit by a member of a home health care team "on any day" be revised to refer

to a visit by a member of a home health care team on “any date of service.” No reason was given for the suggested change.

RESPONSE: The Board does not understand the distinction the commenter wishes to make. The Board notes that since the number of home health care visits are not limited, the accumulation of a number of home health care visits has no impact on the duration of the benefits. No change is being made in response to this comment.

COMMENT 21: One commenter suggested that the preposition “of” be replaced with “for” in the phrase “physical complications of mastectomy, including lymphedemas.”

RESPONSE 21: The Board disagrees with the commenter. The mastectomy could lead to a complication. Therefore, it would be a complication of mastectomy. No change is being made in response to this comment.

COMMENT 22: One commenter asked if the specimen HMO coinsurance schedule page correctly referred to 100% coinsurance following a copayment and suggested that 100% should read 0%.

RESPONSE: The Board agrees with the commenter and has made the suggested change.

COMMENT 23: One commenter asked whether the network and non-network columns on the HMO-POS schedule page may include the specific deductible and coinsurance amounts.

RESPONSE: It is the Board’s intention that carriers will issue schedule pages that specify the elected deductible and coinsurance values.

COMMENT 24: One commenter asked why it was no longer permissible to combine the waiver form, Exhibit T with the enrollment form, Exhibit Q.

RESPONSE: The Board proposed the repeal of Exhibit Q, the enrollment form, since the use of the Board created enrollment form was superceded by the standard enrollment form created by the New Jersey Department of Banking and Insurance pursuant to N.J.S.A. 17:1-8.1 and 17:1-15e and P.L. 1999, c. 339. Thus the waiver form can no longer be combined with Exhibit Q since Exhibit Q no longer exists.

COMMENT 25: One commenter asked if 75 percent is the minimum participation requirement rather than the maximum participation requirement.

RESPONSE: Seventy-five percent is the minimum participation requirement for each employer. A group that does not meet the minimum 75 percent participation requirement is ineligible for coverage under the Board's regulations. A carrier may not require greater than 75 percent participation.

COMMENT 26: One commenter stated that "NJAC 11:21-4.2(a)(1) adds a 45-day requirement prior to an amendment effective date." The comment was not clear and the Board assumes that the commenter perhaps believes the 45-day period is applicable to plan amendments an employer may request. The commenter asked that the 45-day period be changed to 30 days for ease of business development decisions and their implementation.

RESPONSE: The Board believes that the commenter has misunderstood the proposed revision to the requirement that carriers file Certification of Compliance forms. The change, as proposed, would require carriers to submit a Certification of Compliance that addresses amendments the Board adopts to the standard plans within 45 days of the

date the amendments are effective. For example, if the Board adopts changes to the standard plans that are effective January 1, carriers would be required to file a Certification of Compliance within 45 days of that date, meaning no later than February 14. The Board believes that allowing a shorter time period in which to file the Certification of Compliance may not provide ample time to carriers to properly complete the Certification. The Board notes that if a carrier wishes to file before the last date on which the filing is due, earlier filings will certainly be accepted.

COMMENT 27: One commenter noted several typographical errors (spelling, punctuation, etc.) in the standard policy forms.

RESPONSE: The Board thanks the commenter for noting the typographical errors and has made the corrections that were suggested.

Summary of Agency Initiated Changes

1. The Board is amending the transplant provision in Appendix Exhibits F, G, W, Y, HH and II to make it clear that the benefit for donor costs associated with transplants is limited to medical costs for the donor and thus would not cover expenses such as travel or hotel accommodations. The standard plans specifically state that coverage is provided to the extent that the services or supplies are medically necessary and appropriate to treat an illness or injury. Since non-medical services such as travel or accommodations are not medically necessary to treat an illness or injury, coverage for such non-medical expenses is precluded based on the medical necessity requirement. The Board is aware that there are some benefit plans that provide coverage for non-medical services in addition to medical services. To eliminate any possible confusion

as to the extent of the donor benefit contained in the standard plans, the Board is amending the transplant benefit, on adoption, to emphasize that the standard plans cover services and supplies that are medical, and no coverage is provided for services that are non-medical.

2. The standard plans, as proposed, included a Coordination of Benefits and Services provision consistent with that proposed November 3, 2003 at 35 N.J.R. 5007(a). The Board is aware that the Department of Banking and Insurance received several comments to that proposal and is making some changes upon adoption. The Board is amending the Coordination of Benefits and Services provision in the standard plans to include those changes. Specifically, the third section in the paragraph of the "Primary and Secondary Plan" section is being amended such that the third sentence begins with the phrase: "During each claim determination period." In addition, the fourth paragraph of the Procedures to be followed by the Secondary plan to calculate benefits section is being amended to note that HMO and other plans may provide for capitation.
3. The Board is amending N.J.A.C. 11:21-7.8(a)2 to remove the reference to N.J.A.C. 11:21-6.3 since this is a section the Board proposed to repeal. The Board is also amending N.J.A.C. 11:21-7.8(a)2 delete the reference to N.J.A.C. 11:21-6.4. In place of the regulatory citations, the Board is amending the text to refer to the enrollment form and waiver form.
4. P.L. 2003, c. 246, signed on January 12, 2004, and effective 180 days after enactment, provides that plans under which dependent coverage is available must, if elected by the employer, offer coverage for a covered person's domestic partner.

Section 54 of the law states that the law applies to plans issued or renewed pursuant to P.L. 1992, c. 162, which is the SEH Act. To accommodate small employers who may elect to make coverage for domestic partners available under their small employer plans, the Board is amending the provisions described below. In order to provide for coverage, the identification of persons eligible for coverage must be revised. The Board is therefore amending the definition of "dependent" in the standard policy forms and in N.J.A.C. 11:21-1.2 to state that "spouse" includes a domestic partner, as defined in P.L. 2003, c. 246. Sections that describe the rights of persons eligible for coverage must be amended to address events unique to a domestic partnership. The Board is thus amending the definition of "late enrollee" in the standard policy forms and in N.J.A.C. 11:21-1.2 to include reference to termination of a domestic partnership. The Board is likewise amending the COBRA Continuation section and Conversion section of the standard policy forms such that domestic partners have the right to continue coverage upon termination of the domestic partnership and convert coverage upon termination of the domestic partnership. Administratively, the employer needs a means to communicate a request for coverage for domestic partners. The Board is therefore amending the Employer Application, Appendix Exhibit N to include questions to allow an employer to state whether the employer wishes the plan to include coverage for domestic partners pursuant to P.L. 2003, c. 246.

5. The Board is retaining the definitions of "coinsurance cap" and "coinsured charge limit" as those terms appear in N.J.A.C. 11:21-1.2 to accommodate the use of

those terms in N.J.A.C. 11:21-3 and 4 and Appendix Exhibits A, F, V, W, HH and II, the amendments to which are not operative until October 1, 2004.

6. The Board is amending the definition of "late enrollee" in N.J.A.C. 11:21-1.2 to make one correction. The definition of late Enrollee is based on the definition as contained in HIPAA and N.J.S.A. 17B:27A-17. In the sentence that discusses employers that offer multiples benefit plans, the clause following the discussion of COBRA discusses a court of competent jurisdiction. The conjunction "or" at the beginning of the clause was inadvertently omitted, and is now being included.

Federal Standards Statement

The readopted rules comply with the following federal laws: the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), 29 U.S.C. §§1161 et seq.; the Employee Retirement Security Act of 1974 (ERISA), 29 U.S.C. §§1001 et seq. and implementing regulations at 26 C.F.R. Part 54, 29 CFR Parts 2520 and 2560, and 32 C.F.R. Part 220; Section 1862(b) of the Social Security Act (Medicare as Secondary Payor), 42 U.S.C. §1395y(b)(1994) and implementing regulations at 45 C.F.R. Part 411; the Public Health Service Act 42 U.S.C.A. §300gg et seq., (incorporating the Federal Health Insurance Portability and Accountability Act of 1996, Pub.L. 104-191; the Newborns' and Mother's Health Care Protection Act of 1998, Pub.L. 104-204, 110 Stat. 2935 (1996); and the Women's Health and Cancer Rights Act of 1998, Pub.L. 105-277, Title IX, §903, 112 Stat.) and implementing regulations at 45 C.F.R. Parts 145 and 146.

The rules do not expand upon the requirements set forth in these Federal laws. There are no other Federal laws that apply to these regulations.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 11:21-1 through 7, 8, 10, 17, 18, 23 and Appendix Exhibits A, F, G, H, N, O, T, V, W, Y, BB Parts 1 and 2, CC, DD, II and KK.

Full text of the adopted amendments and new rules follows (additions to proposal indicated in boldface with asteriska *thus*; deletions from proposal indicated in cursive brackets *[thus]*):

11:21-1.2 Definitions

. . .

***"Coinsurance cap" means the maximum amount a covered person is required to pay as a result of the application of the coinsurance under the standard plans, as set forth in the Appendix Exhibits to this chapter. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsurance cap.**

"Coinsured charge limit" means, with respect to a preferred provider organization (PPO) plan, or a point of service (POS) plan, developed based on the standard health benefit plans set forth in the Appendix Exhibits to this chapter, the amount of covered charges a covered person must incur before no coinsurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the coinsured charge limit.

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan. ***At the option of the small employer, "spouse" includes a domestic partner pursuant to P.L. 2003, c. 246.***

. . .

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment, but only if the plan sponsor or carrier required such statement at that time and provided the employee with notice of that requirement and the consequences of that requirement at that time; has lost coverage under that other employer's health benefits plan as a result of termination of employment or eligibility, reduction in the number of hours of employment, involuntary termination, the termination of the other plan's coverage, death of a spouse, or divorce or legal separation ***or termination of a domestic partnership***; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; the individual had coverage under a COBRA continuation provision and the coverage under that provision was exhausted and the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage; ***or*** if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a

covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order or initially waived coverage under the policy for himself or herself and any then existing dependents provided the employee enrolls to cover himself or herself and his or her existing dependent spouse, if any, under the policy within 30 days of the marriage, birth, adoption or placement for adoption of a newly acquired dependent.

. . .

11:21-7.8 Effective date of coverage

(a) A small employer carrier, prior to issuing a health benefits plan, may require the following:

1. (No change)
2. Complete employee enrollment ***{material in accordance with N.J.A.C. 11:21-6.3 and 6.4}*** ***forms and waiver forms***; and
3. (No change)

(b) – (e) (No change).

. . .

2/18/04 _____

Date Wardell Sanders, Executive Director