Full text of the corrected rule follows (additions indicated in boldface **thus**; deletion indicated in brackets [thus]):

SUBCHAPTER 1. GENERAL PROVISIONS

8:96-1.2 Definitions

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

["Health benefits plan" means a plan that pays or provides hospital and medical expense benefits for covered services, and is delivered or issued for delivery in this State by or through a carrier, but does not include the following plans, policies, or contracts: Medicaid, Medicare, Medicare Advantage, accident only, credit, disability, long-term care, TRICARE supplement coverage, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, personal injury protection insurance issued pursuant to P.L. 1972, c. 70 (N.J.S.A. 39:6A-1 et seq.), a dental plan as defined pursuant to section 1 of P.L. 2014, c. 70 (N.J.S.A. 26:2S-26), and hospital confinement indemnity coverage.]

"American Institute of Certified Public Accountants" or "AICPA" means the entity by that name for which the contact information is AICPA, 220 Leigh Farm Road, Durham, NC 27707-8110, telephone (888) 777-7077, telefacsimile (800) 362-5066, website: http://www.aicpa.org.

"Audited," as used to describe financial statements, or a statement of operations or income, means that an independent certified public accountant (ICPA) audited the subject document(s) using GAAS, and attested thereto as presented in accordance with GAAP.

"Department" means the New Jersey Department of Health, for which the contact information for submissions that this chapter requires is:

1. By regular mail:
Hospital Finance and Charity Care Program
New Jersey Department of Health
PO Box 360
Trenton, NJ 08625-0360

2. By overnight delivery service or hand delivery:
Hospital Finance and Charity Care Program
New Jersey Department of Health
225 East State Street, 2nd Floor, West Wing
Trenton, NJ 08608-1800

3. By electronic mail: financial.reports@doh.nj.gov

"Electronic Data Gathering Analysis and Retrieval system" or "EDGAR system" means an online web-based platform that the United States Securities and Exchange Commission operates at https://www.sec.gov/edgar.shtml.

"Electronic Municipal Market Access system" or "EMMA® system" means an online web-based platform that the Municipal Securities Rulemaking Board operates at http://emma.msrb.org.

"Financial statements" means, collectively, the statements, schedules, and notes that GAAP requires for presentation of financial statements.

"Generally accepted accounting principles" or "GAAP" means the accounting principles that a reporting entity determines to be applicable, and that are generally accepted in the United States as authoritative by:

1. The Financial Accounting Standards Board (FASB) with respect to nongovernmental entities, as articulated in the *Financial Accounting Standards Board Accounting Standards Codification*® (2009), as amended and supplemented, available at www.fasb.org, and from the FASB at 401 Merritt 7, PO Box 5116, Norwalk, CT 06856-5116; or

2. The Governmental Accounting Standards Board (GASB) with respect to State and local governmental entities, as articulated in the GASB *Codification of Governmental Accounting and Financial Reporting Standards* (2017), as amended and supplemented, available at www.gasb.org, and from the GASB at 401 Merritt 7, PO Box 5116, Norwalk, CT 06856-5116.

"Generally accepted auditing standards" or "GAAS" means the auditing standards that are generally accepted in the United States as authoritative, as specified in the AICPA *Professional Standards* (2015), as amended and supplemented, available from the AICPA.

"Hospital" means a general hospital that the Department licenses pursuant to N.J.A.C. 8:43G.

"Reporting period" means the reporting period a hospital specifies pursuant to N.J.A.C. 8:31B-4.6.

"Statement of operations or income" means statement of operations or income, as GAAP defines and/or describes that term, also commonly referred to as statement of operations, income statement, statement of revenues and expenses, earnings statement, or profit and loss statement.

"System hospital" means a hospital that is part of a network or system of hospitals and/or other health care facilities that commonly is referred to as a health care system.

"Unaudited," as used to describe financial statements, or a statement of operations or income, means that an ICPA neither audited the subject document(s) using GAAS, nor attested thereto as presented in accordance with GAAP.

INSURANCE

(a)

DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE
Actuarial Services
Readoption with Amendments: N.J.A.C. 11:4
Adopted Repeals and New Rules: N.J.A.C. 11:4-13.3
Adopted New Rules: N.J.A.C. 11:4-13.4, 16.2A, 16.6A, and 19.2A
Adopted Repeals: N.J.A.C. 11:4-15 and 11:4-56 Appendix A

Proposed: November 5, 2018, at 50 N.J.R. 2196(a).
Adopted: March 26, 2019, by Marlene Caride, Commissioner, Department of Banking and Insurance.
Filed: March 27, 2019, as R.2019 d.034, **with non-substantial changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-6.3), **and with the proposed amendments to N.J.A.C. 11:4-56.2 not adopted but still pending**.

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

Effective Dates: March 27, 2019, Readoption;
May 6, 2019, Amendments, Repeals, and New Rules.
Expiration Date: March 27, 2026.

Summary of Public Comment and Agency Response:
No comments were received.

Federal Standards Statement

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

Full text of the readopted rules can be found in the New Jersey Administrative Code at N.J.A.C. 11:4.

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

SUBCHAPTER 2. LIFE INSURANCE AND ANNUITIES REPLACEMENT

11:4-2.3 Duties of producers

(a) (No change.)

(b) If the applicant answers "yes" to the question regarding existing coverage referred to in (a) above, the producer shall present and offer to

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

1.-3. (No change.)

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

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

11:4-7.3 Filing requirements

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

(b) Each application shall include the following information:

1.-8. (No change.)

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

10.-11. (No change.)

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

11:4-13.2 Definitions

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

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

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

. . .

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

11:4-13.3 Prohibited provisions

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

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

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

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

2. Forms shall be submitted as follows:

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

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

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

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

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

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

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

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

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

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

vi. Services included in "other" category;

vii. Adjustments and support for the following factors:

(1) Changes in benefits, if any;

(2) Changes in morbidity, if any;

(3) Demographics changes, if any;

(4) Network changes, if any; and

(5) Other changes, if any.

viii. Credibility assigned to experience and credibility methodology used;

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

x. A rating example;

xi. Quality improvement expenses;

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

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

SUBCHAPTER 15. (RESERVED)

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

11:4-16.2A Definitions

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

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

insurance benefits. Health benefits plan shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and such other similar, limited benefits as are specified in Federal regulations. Health benefits plan shall not include hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor. Health benefits plan shall not include the following if it is offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Federal Social Security Act (42 U.S.C. § 1395ss(g)(1)); and coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10 U.S.C. §§ 1071 et seq.); and similar supplemental coverage provided to coverage under a group health plan.

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

11:4-16.4 Policy definitions

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

1. (No change.)

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

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

i.-ii. (No change.)

4.-17. (No change.)

11:4-16.5 Prohibited policy provisions

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

(d) (No change in text.)

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

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

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

1.-2. (No change.)

(i) (No change in text.)

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

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

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

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

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

i. (No change.)

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

iii.-iv. (No change.)

5.-9. (No change.)

10. Eyeglasses, hearing aids, and examinations for the prescription or fitting thereof; however, health benefits plans shall not exclude coverage for hearing aids consistent with P.L. 2008, c. 126;

11.-12. (No change.)

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

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

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

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

11:4-16.6 Minimum standards for benefits

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

(b) (No change.)

(c) General rules include the following:

1.-2. (No change.)

3. In a family policy covering spouses the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definition of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (for example, age

65) so long as the policy may be continued in force as to the younger spouse to the age or for the duration specified in said definition.

4.-22. (No change.)

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

1. (No change.)

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

i. (No change.)

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

(1) (No change.)

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

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

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

3.-4. (No change.)

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

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

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

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

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

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

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

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

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

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

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

11:4-16.8 Required disclosure provisions

(a) (No change.)

(b) Outline of coverage—general rules include:

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

i.-ii. (No change.)

2.-9. (No change.)

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

SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION

11:4-17.3 Definitions

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

. . .

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

. . .

11:4-17.5 Replacement

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

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

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

11:4-18.2 Applicability and scope

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

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

11:4-19.2 Scope

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

11:4-19.2A Definitions

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

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

11:4-19.4 Maternity benefits option

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

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

SUBCHAPTER 35. VIATICAL SETTLEMENTS

11:4-35.1 Purpose and scope

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

(b) (No change.)

11:4-35.2 Definitions

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

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

. . .

11:4-35.3 General licensing requirements

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

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

11:4-35.12 Payment of the proceeds

(a) (No change.)

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

(c) (No change.)

11:4-35.16 Disclosure

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

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

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

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

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

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

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

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

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

(a) (No change.)

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

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

New Jersey Department of Banking and Insurance
Office of Managed Care, 9th floor
Consumer Protection Services
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

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

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

11:4-42.2 Definitions

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

. . .

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

. . .

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

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

1.-4. (No change.)

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

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

(a) (No change.)

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

1.-4. (No change.)

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

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

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

(b) (No change.)

SUBCHAPTER 50. REIMBURSEMENT OF INMATE HEALTH CARE COSTS

11:4-50.5 Health coverage plans

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

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

(d) (No change.)

SUBCHAPTER 52. LIFE INSURANCE ILLUSTRATIONS

11:4-52.9 Annual certifications

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

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

New Jersey Department of Banking and Insurance
Life and Health Actuarial
PO Box 325
Trenton, New Jersey 08625-0325

(h) (No change.)

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

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

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

1. (No change.)

2. A completed Checklist and Certification with information regarding administration, underwriting requirements, and coverage services that assists the Department in verifying compliance with N.J.S.A. 17B:27A-48 can be found on the Department's website at: www.state.nj.us/dobi/division_insurance/lifehealthmain.html;

3.-15. (No change.)

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

APPENDIX A (RESERVED)

SUBCHAPTER 57. MANDATED BENEFITS FOR BIOLOGICALLY-BASED MENTAL ILLNESS

11:4-57.3 Exclusions and benefit limits

(a) (No change.)

(b) Subject to (a) above, carriers may apply preauthorization requirements, to treatment of biologically-based mental illness only if those requirements are applicable to treatments of physical illnesses and consistent with the requirements of the Federal Mental Health Parity and

Addiction Equity Act of 2008 (MHPAEA) part of Public Law 110-343, and further:

1. Visit limits are prohibited; and

2. Preauthorization requirements:

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

ii. Preauthorization of particular services for the treatment of biologically-based mental illness is permitted only if consistent with MHPAEA.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS

OFFICE OF THE DIRECTOR

Prescription Monitoring Program

Delegate Access: Athletic Trainers and Medical Scribes Employed by a Hospital's Emergency Department; Access to Prescription Monitoring Information: Electronic Health Record System; Requirements for Mandatory Look-Up; Patient Requests to Correct Inaccurate Information

Adopted Amendments: N.J.A.C. 13:45A-35.1, 35.2, 35.3, 35.6, 35.7, 35.8, 35.9, and 35.11

Adopted New Rules: N.J.A.C. 13:45A-35.6A and 35.12

Proposed: October 15, 2018, at 50 N.J.R. 2138(a).
Adopted: March 5, 2019, by Paul R. Rodríguez, Acting Director, Division of Consumer Affairs.
Filed: March 25, 2019, as R.2019 d.033, **without change**.

Authority: N.J.S.A. 45:1-45 et seq. (P.L. 2007, c. 244, as amended by P.L. 2015, c. 74 and P.L. 2017, c. 341).

Effective Date: May 6, 2019.
Expiration Date: January 16, 2026.

Summary of Public Comment and Agency Response:

The official comment period ended December 14, 2018. The Division of Consumer Affairs (Division) received one comment from Melinda R. Martinson, General Counsel, Medical Society of New Jersey.

1. COMMENT: The commenter expressed support for the process for patients to request the correction of inaccurate information in the program. The commenter is aware of a number of physicians who have had prescriptions inaccurately attributed to them as prescribers and the burden has been on the physician to seek the correction, which may or may not have involved a patient. The commenter urged the Division to support physicians' efforts to correct prescriptions inaccurately attributed to them and noted that patients, physicians, and society at large benefit from accurate prescribing information in the Prescription Drug Monitoring Program (PMP).

The commenter also expressed support for the new flexibility for physicians and other authorized individuals to access prescription monitoring information from electronic systems connecting hospital emergency departments, so long as appropriate security protections are in place. The commenter reiterated that flexibility and ease of access help to facilitate compliance with the program's requirements.

RESPONSE: The Division thanks the commenter for her support.

Federal Standards Statement

A Federal standards analysis is not required because the adopted amendments and new rules are governed by N.J.S.A. 45:1-45 et seq. (P.L. 2007, c. 244, as amended by P.L. 2015, c. 74 and P.L. 2017, c. 341). However, in accordance with existing N.J.A.C. 13:45A-35.5(h), all persons authorized to access PMP prescription drug information, including licensed athletic trainers and medical scribes, must comply with the Federal Health Insurance Portability and Accountability Act of 1996 and the Federal health privacy rules set forth at 45 CFR Parts 160 and 164.

Full text of the adoption follows:

SUBCHAPTER 35. PRESCRIPTION MONITORING PROGRAM

13:45A-35.1 Purpose and scope

(a) The rules in this subchapter implement the provisions of P.L. 2007, c. 244, as amended by P.L. 2015, c. 74 and P.L. 2017, c. 341 (N.J.S.A. 45:1-44 through 51), establishing a Prescription Monitoring Program (PMP) in the Division of Consumer Affairs.

(b) The rules in this subchapter shall apply to the following:

1.-9. (No change.)

10. A registered dental assistant authorized by a licensed dentist to access the prescription monitoring information, subject to the limitations and requirements of this subchapter;

11. A licensed mental health practitioner providing treatment for substance abuse to patients at a residential or outpatient substance abuse treatment center licensed by the Department of Health, subject to the limitations and requirements of this subchapter;

12. A licensed athletic trainer authorized by a practitioner to access the prescription monitoring information, subject to the limitations and requirements of this subchapter; and

13. A medical scribe authorized by a practitioner to access the prescription monitoring information, subject to the limitations and requirements of this subchapter.

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

13:45A-35.2 Definitions

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

. . .

"Certified medical assistant" means a person who is a graduate of a post-secondary medical assisting educational program accredited by the Commission on Allied Health Education and Accreditation (CAHEA), or its successor, the Accrediting Bureau of Health Education Schools (ABHES), or its successor, or any accrediting agency recognized by the U.S. Department of Education, which educational program includes, at a minimum, 330 clock-hours of instruction, and encompasses training in the administration of intramuscular and subcutaneous injections, as well as instruction and demonstration in: pertinent anatomy and physiology appropriate to injection procedures; choice of equipment; proper technique, including sterile technique; hazards and complications; and emergency procedures; and who maintains current certification or registration, as appropriate, from the Certifying Board of the American Association of Medical Assistants (AAMA), the National Center for Competency Testing (NCCT), the National Healthcareer Association (NHA), the American Medical Certification Association (AMCA), the National Certification Medical Association (NCMA), the American Medical Technologists (AMT), or any other recognized certifying body approved by the Board of Medical Examiners. A "clock-hour" shall be calculated at the rate of one hour for every 50 minutes of in-class participation.

"Chronic pain" means pain that persists or recurs for more than three months.

. . .

"Licensed athletic trainer" means an individual who is licensed by the State Board of Medical Examiners to practice athletic training, pursuant to the Athletic Training Licensure Act, P.L. 1984, c. 203 (N.J.S.A. 45:9-37.35 et seq.).

. . .

"Medical scribe" means an individual trained in medical documentation who assists a physician or other licensed health care professional by documenting the patient's encounter with the professional in the patient's medical record and gathering data for the professional, including, but not limited to, nursing notes, patient medical records, laboratory work, and radiology tests.

. . .