

EXPLANATION OF BRACKETS

Plans B through E Policy and Certificate (Appendix Exhibits F and W for Plans B – E)

All text which is enclosed in brackets [] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

- a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC]
- b) Some areas of variability are noted with brief explanations within the text. Examples include: use of PPO, EPO and POS text.
- c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
- d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation
- e) Some areas of variability are determined by the election made by a Carrier.
- f) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
- g) Some areas of variability are determined by the delivery system (i.e., indemnity, PPO, POS or EPO)
- h) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.
- i) Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (SHOP).

Note: Due to the complexity of issuing plans through or in conjunction with an approved Selective Contracting Arrangement, commonly known as PPO or POS or EPO plans, explicit guidance is set forth in item 29 below.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is generally consistent with the order of appearance in the policy and certificate forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that could pay dividends.
2. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
3. Although the schedule pages specify the plan letter in the upper right corner this identification is intended solely to identify which plan letter the page illustrates. Carriers need not specify the plan letter on the schedule pages of plans being issued.
4. Deductible, Co-Insurance, and Copayments may be elected by the Employer, subject to the availability specified in regulation.
5. There are alternate PPO and POS schedule pages that allow carriers to use separate or common deductible and maximum out of pocket provisions. These features may be used, at the option of the carrier. There are corresponding provisions in the benefit provisions.
6. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in the PPO, POS and EPO descriptions and other coverage sections of the policy.
7. The list of services and supplies for which pre-approval is required includes two items, included in brackets: specified therapies and prescription drugs. The benefit provisions for these services and supplies also includes text in brackets concerning pre-approval. Carriers that elect to require pre-approval for these services and supplies must include them on the list on the schedule page in addition to using the pre-approval text in the benefit provision.
8. The Reinstatement provision may be included or omitted, at the option of the carrier. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
9. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy - Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
10. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
11. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.
12. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the policy form.
13. The definition of Referral should be included in POS plans that require referrals.
14. The "Actively at Work" requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.

15. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.
16. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 90 days and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 2months. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
17. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
18. The text describing provider compensation in the PPO and POS sections contains a number of bracketed words and phrases. Include the words and phrases that describe the arrangement carrier has with network providers.
19. The continuation of care text must be included in all plans that use networks.
20. The treatment of hemophilia provision includes variable text that would only be included in managed care plans.
21. The prescription drugs provision includes variable text that would be included by carriers that require pre-approval for specified drugs.
22. The therapy services provision includes variable text that would be included by carriers that require pre-approval for certain therapy services.
23. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. For Carriers electing to include the optional cancer treatment benefits as part of the standard forms, the list of services for which Pre-Approval is required, as it appears in the Schedule of Benefits, must be modified to omit the item for autologous bone marrow transplant and associated dose intensive chemotherapy.
24. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty.
25. The Specialty Case Management provision may be omitted. Carriers may administratively provide for such provisions. If included in the policy and certificate, the text must conform to the text of the standard form.
26. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.
27. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a

SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

28. Carriers that issue plans through or in conjunction with an approved Selective Contracting Arrangement must consider the following when creating the plan documents:
 - a. The policy and certificate documents contain “SAMPLE” schedule page text. The dollar amounts for the deductibles and copayments are purely illustrative. Refer to N.J.A.C. 11:21-3(d) for direction as to which amounts may be substituted for those in the example. For plans that utilize a copay feature, the copays replace the cash deductible for the particular service, and benefits following the copay must be paid at 100%. The dollar amounts for the copays must be consistent with those that an HMO carrier may use.
 - b. Include the specific page of text describing either the PPO, POS or the EPO mechanism, with specification of the name of the network or provider organization.

In **addition** to the above items, Carriers must consider the following in connection with the certificate forms:

29. The face page text may be modified to be consistent with a carrier’s methods of certificate personalization. The certificate level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue “no-name” certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
30. The term “certificate” may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer’s group plan.
31. Variable schedule data such as deductible, and copayment amounts may be included on the schedule, shown on the face page, sticker or separate schedule.
32. The Payment of Premiums-Grace Period section may be omitted, at the carrier’s option.
33. The definition of “You, Your and Yours” may be omitted by carriers that elect to refer to the employee as Employee, rather than use the personal “You”. Throughout the text, the words “You,” “Your” and “Yours” must be replaced with “Employee” terminology.

Plan HMO Contract and Evidence of Coverage (Appendix Exhibits G and Y)

All text which is enclosed in brackets [] is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either

include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in the following ways.

- a) Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], and [ABC].
- b) Some areas of variability are noted with brief explanations within the text.
- c) Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
- d) Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.
- e) Some areas of variability are intended solely to accommodate plans that only allow coverage for employees. That is, no dependent coverage is available. In such circumstances, references to dependents and provisions that apply to dependents, as enclosed in brackets, may be omitted. When dependent coverage is provided under the plan, all dependent text must be included in the plan.
- f) Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.
- g) Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act, Public Law 111-152 (SHOP).

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract and Evidence of Coverage forms.

- 1. The Health Care Quality Act requires carriers to specify the legal name, trade name fax and e-mail numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
- 2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
- 3. Copayments may be elected by the Employer, subject to the availability specified in regulation.
- 4. Deductible, coinsurance and maximum out of pocket provisions may be included for network benefits. Applicable text to address the deductible, coinsurance and maximum out of pocket features must be included on the schedule page and in the benefit provisions.
- 5. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is

applicable. Additional variable text addressing a tiered network is included in other coverage sections of the contract.

6. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
7. The method a Carrier chooses to make the optional cancer treatment benefits available will determine which transplant benefit text the Carrier would include. **NOTE:** ALL plans issued by a Carrier must make the optional benefit available in the same manner.
8. The bracketed dispensing limit text contained in the prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
9. Eligible class references can be removed.
10. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 90 days and must satisfy the requirements of regulation. The text may address a date certain following a waiting period, such as first of the month following 60 days. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
11. The date Employee and Dependent coverage begins or ends may vary to accommodate Employer and/or Carrier administration practices. For example, Coverage may begin as of the first of the month following any waiting period, or coverage may end immediately or may end at the end of the month following a termination event.
12. Percentage participation requirement as noted in the Participation Requirements and in the Termination of the Policy Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
13. Transfer of Primary Care Physician can occur according to carrier administration, but may not be more restrictive to the member than stated in the form.
14. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
15. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
16. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
17. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a

SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

In addition to the above items, Carriers must consider the following in connection with the evidence of coverage forms:

18. The face page text may be modified to be consistent with a carrier's methods of evidence of coverage personalization. The evidence of coverage level data that is illustrated on the face page of the standard forms may appear on a separate schedule, or sticker, or may be incorporated in the body of the document. Carriers may also elect to issue "no-name" certificates, which would fully describe eligibility and effective date provisions such that the covered persons could apply the rules to determine the terms of their coverage.
19. The term "evidence of coverage" may be replaced with a similar term used to identify the document provided to employees covered under an employer's group plan.

Plan HMO-POS Contract and Evidence of Coverage (Appendix Exhibits HH and II)

All text which is enclosed in brackets is variable. Enclosure in Brackets does **not** give Carriers liberty to deviate from the standard text which is enclosed in brackets, except as expressly stated. In many instances, variable text is text which a carrier elects to either include or exclude. When the forms are prepared as issue documents, no brackets should appear, since the forms, as issued, should specify all the elections the Carrier has made. Such text may generally be categorized in five ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contractholder], [date].
2. Some areas of variability are noted with brief explanations within the text.
3. Some areas of variability are intended to allow for flexibility in terms of a Carrier's administrative practices.
4. Some areas of variability are subject to ranges specified in statute or regulation.
5. Some areas of variability are determined by Carrier elections. [Examples include terms to identify the member, network and non-network benefits.]
6. Variable text is included throughout the forms to address the potential for coverage for domestic partners. Carriers should include the text only if the employer elects coverage for domestic partners on the employer application. In lieu of including the text in the body of the form, carriers may use the Open Face Rider (Exhibit D) to include the domestic partner text as included in the standard plans.
7. Some areas of variability apply to the limited circumstance of plans to be issued in the Small Business Health Options Program created under the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by

The following explanations apply to the Contract and Evidence of Coverage, unless otherwise stated.

1. The Health Care Quality Act requires carriers to specify the legal name, trade name, e-mail and fax numbers. Carriers may include this information on a separate page, immediately following the face page, as illustrated in the standard forms. Alternatively, carriers may include this information directly on the face page.
2. The definition of an Approved Cancer Clinical Trial and the corresponding benefit provision should be included only by those carriers that wish to make such coverage available and want to specify such coverage in the contract form.
3. The forms define and use the terms “Network” or “In-Network” and “Non-Network” or “Out-of-Network.” Carriers may replace those terms as they appear in the definitions section, and elsewhere throughout the forms, with alternate terms. (Example: Participating, Non-Participating)
4. The forms define and use the term “Member.” Carriers may replace that term as it appears in the definitions section, and elsewhere throughout the forms, with an alternate term. (Examples: Subscriber, Enrollee)
5. The plan may be issued as employee only coverage. Text which addresses dependent coverage, as enclosed in brackets, may be deleted for plans which only make coverage available to employees.
6. Carriers should include variable material contained in the Provider Payment section to correctly address the compensation arrangement the carriers have with the network.
7. Copayment, deductible, coinsurance and maximum out of pocket amounts may be elected by the Contractholder, subject to the availability specified in regulation. The applicable schedule page and benefit provision text should be included, consistent with whether deductible and coinsurance provision applies to both network and non-network benefits or only to non-network benefits.
8. One of the schedule pages illustrates a tiered network design. Carriers should adapt the schedule page to illustrate the services for which a tiered network design is applicable. Additional variable text addressing a tiered network is included in other coverage sections of the contract.
9. The “Actively at Work” requirement may be deleted. To accomplish the deletion of the actively at work requirement, carriers must delete the definition of Actively at Work, and delete the bracketed text in the following sections: Eligible Employees, Full-Time Requirement, When Employee Coverage Starts, Exception to the Actively at Work Requirement, and When Employee Coverage Ends.
10. The definition of “Employer” should identify the name of the employer or specify the location in the Contract and Evidence of Coverage where the employer name is specified.
11. The “Waiting Period” provision may be omitted, or included, at the option of the Contractholder. If included, the duration of the waiting period may not exceed 90 days. The text may address a date certain following a waiting period, such as first of the month following 60 days. If included, the carrier may include the bracketed definition of Waiting Period in the Definitions section.
12. The date employee or dependent coverage begins or ends may vary, to accommodate Contractholder, or Carrier administration practices. (Example: Coverage may begin as of the first of the month following any waiting period. Coverage may end immediately, or at the end of the month in which the termination event occurs.)

13. The Selection or Change of a Primary Care Physician or Health Center, and the effective date of the selection or transfer may vary according to Carrier administration, but may not be more restrictive to the member than stated in the form.
14. Carriers may elect to make the optional cancer treatment benefit available as part of the standard plan or as an optional benefit rider. The selected option determines which text the Carrier should include. *Note:* All plans issued by a Carrier must reflect the same Carrier election to either include the optional benefit, or make the benefit available by rider.
15. The bracketed dispensing limit text contained in the network prescription drug coverage should be deleted by carriers that provide the in-plan prescription drug coverage subject to coinsurance.
16. Carriers that wish to apply pre-approval requirements to the Prescription Drugs coverage should include the variable pre-approval text.
17. Carriers that wish to apply pre-approval requirements to non-network prescription drug coverage should include the variable pre-approval text.
18. The Utilization Review Features may be omitted in its entirety, or specific sections may be omitted. The penalty for non-compliance may be adjusted to specify a percentage or a dollar penalty. A Carrier that wishes to use alternate text to describe utilization review provisions must submit the text to the Board and the Department of Insurance, pursuant to N.J.A.C. 11:21-4.2.
19. The “Specialty Case Management” provision may be omitted. Carriers may provide for such “case management” administratively. If included in the form, the text must conform to the text of the standard form.
20. The “Centers of Excellence” provision may be omitted. If included in the form, the text must conform to the text of the standard form.
21. Percentage participation requirements (specified as 75% in the forms) may be modified by the Carrier, provided the Carrier complies with N.J.A.C. 11:21-7.6.
22. The Reinstatement provision should be included by carriers that will allow reinstatement. The provision includes two options for a reinstatement fee. Carriers should include the applicable text.
23. The “Notice of Loss” section of the “Claims Provisions” may be omitted, at the option of the Carrier.
24. The third sentence of the “Payment of Claims” section of the “Claims Provisions” should be omitted, if not applicable.
20. The Dental Benefits text is enclosed in brackets. For policies sold on the SHOP the Dental Benefits provision may be excluded if the SHOP offers a standalone dental plan with a pediatric dental essential health benefit. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an employer is providing such pediatric dental coverage through a SHOP-certified stand-alone dental plan. Dental benefits may be limited to services provided by a network provider.

The following explanations apply only to the Evidence of Coverage.

- 1) The face page of the Evidence of Coverage may be modified to reflect a Carrier's method of personalization. Only that text which pertains to the manner of identifying the covered person may be modified.
- 2) The term "Evidence of Coverage" may be replaced with another term which the Carrier uses to name the document given to covered persons. If another name is used, the Carrier should make similar name changes in the corresponding Contract form.
- 3) The Introduction contains bracketed areas which should be omitted, if not applicable, or modified to specify appropriate information.