CHAPTER 361

AN ACT extending the health benefits coverage of a newborn infant and amending various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Section 6 of P.L.1938, c.366 (C.17:48-6) is amended to read as follows:

C.17:48-6 Contracts; certificates; contents.

6. Every individual contract made by a corporation subject to the provisions of this chapter to furnish services to a subscriber shall provide for the furnishing of services for a period of 12 months, and no contract shall be made providing for the inception of such services at a date later than 1 year after the actual date of the making of such contract. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been at least 30 days' prior written notice of termination by either the subscriber or the corporation. In the absence of fraud or material misrepresentation in the application for a contract or for reinstatement, no contract with an individual subscriber shall be terminated by the corporation unless all contracts of the same type, in the same group or covering the same classification of persons are terminated under the same conditions.

No contract between any such corporation and a subscriber shall entitle more than one person to services, except that a contract issued as a family contract may provide that services will be furnished to a husband and wife, or husband, wife and their dependent child or children, or the subscriber and his (or her) dependent child or children. Adult dependent(s) of a subscriber may also be included for coverage under the contract of such subscriber.

Whenever, pursuant to the provisions of a subscription certificate or group contract issued by a corporation, the former spouse of a named subscriber under such a certificate or contract is no longer entitled to coverage as an eligible dependent by reason of divorce, separate coverage for such former spouse shall be made available by the corporation on an individual non-group basis under the following conditions:

(a) Application for such non-group coverage shall be made to the corporation by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(b) No new evidence of insurability shall be required in connection with the application for such non-group coverage but any health exception, limitation or exclusion applicable to said former spouse under the prior coverage may, at the option of the corporation, be carried over to the new non-group coverage.

(c) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(d) The benefits provided under the non-group coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the corporation to new non-group applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within 60 days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a hospital service corporation to insure as a covered dependent any child with an intellectual disability or physically handicapped child of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physically handicapped child from coverage.

Every individual contract entered into by any such corporation with any subscriber thereto shall be in writing and a certificate stating the terms and conditions thereof shall be furnished to the subscriber to be kept by him. No such certificate form shall be made, issued or delivered in this State unless it contains the following provisions:

(a) A statement of the contract rate, or amount payable to the corporation by or on behalf of the subscriber for the original quarter-annual period of coverage and of the time or times at which, and the manner in which, such amount is to be paid; and a provision requiring 30 days' written notice to the subscriber before any change in the contract, including a change in the amount of subscription rate, shall take effect;

(b) A statement of the nature of the services to be furnished and the period during which they will be furnished; and if there are any services to be excepted, a detailed statement of such exceptions printed as hereinafter specified;

(c) A statement of the terms and conditions, if any, upon which the contract may be amended on approval of the commissioner or canceled or otherwise terminated at the option of either party. Any notice to the subscriber shall be effective if sent by mail to the subscriber's address as shown at the time on the plan's record, except that, in the case of persons for whom payment of the contract is made through a remitting agent, any such notice to the subscriber shall also be effective if a personalized notice is sent to the remitting agent for delivery to the subscriber, in which case it shall be the responsibility of the remitting agent to make such delivery. The notice to the subscriber as herein required shall be sent at least 30 days before the amendment, cancellation or termination of the contract takes effect. Any rider or endorsement accompanying such notice, and amending the rates or other provisions of the contract, shall be deemed to be a part of the contract as of the effective date of such rider or endorsement;

(d) A statement that the contract includes the endorsements thereon and attached papers, if any, and contains the entire contract for services;

(e) A statement that no statement by the subscriber in his application for a contract shall avoid the contract or be used in any legal proceeding thereunder, unless such application or an

exact copy thereof is included in or attached to such contract, and that no agent or representative of such corporation, other than an officer or officers designated therein, is authorized to change the contract or waive any of its provisions;

(f) A statement that if the subscriber defaults in making any payment under the contract, the subsequent acceptance of a payment by the corporation or by one of its duly authorized agents shall reinstate the contract, but with respect to sickness and injury may cover such sickness as may be first manifested more than 10 days after the date of such acceptance;

(g) A statement of the period of grace which will be allowed the subscriber for making any payment due under the contract. Such period shall be not less than 10 days.

In every such contract made, issued or delivered in this State:

(a) All printed portions shall be plainly printed in type of which the face is not smaller than 10 point;

(b) There shall be a brief description of the contract on its first page and on its filing back in type of which the face is not smaller than 14 point;

(c) The exceptions of the contract shall appear with the same prominence as the benefits to which they apply; and

(d) If the contract contains any provision purporting to make any portion of the articles, constitution or bylaws of the corporation a part of the contract, such portion shall be set forth in full.

2. Section 2 of P.L.1964, c.104 (C.17:48-6.1) is amended to read as follows:

C.17:48-6.1 Group contracts issued by hospital service corporation.

2. A hospital service corporation may issue to a policyholder a group contract, covering at least two employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions, or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the

required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within 60 days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such conditions, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a hospital service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall provide that, subject to payment of the appropriate premium, such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the individual proprietor or partners of an individual proprietorship or a partnership. The contract may provide that the term "employees" shall include retired employees. A contract issued to trustees may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A contract issued to the trustees of a fund established by the members of an association of employers may provide that the term "employees" shall include the employees of the association.

3. Section 5 of P.L.1940, c.74 (C.17:48A-5) is amended to read as follows:

C.17:48A-5 Subscription contracts.

5. Every individual contract made by any corporation subject to the provisions of this chapter to provide payment for medical services shall provide for the payment of medical services for a period of 12 months from the date of issue of the subscription certificate. Any such contract may provide that it shall be automatically renewed from year to year unless there shall have been 1 month's prior written notice of termination by either the subscriber or the corporation. In the absence of fraud or material misrepresentation in the application for contract or for reinstatement, no contract with an individual subscriber shall be terminated by the corporation unless all contracts of the same type, in the same group or covering the same classification of persons are terminated under the same conditions. No contract between such corporation and subscriber shall allow for the payment for medical services for more than one person, except that a family contract may provide that payment will be made for medical services rendered to a subscriber and any of those dependents defined in section 1 of this act.

Whenever, pursuant to the provisions of a subscription certificate or group contract issued by a corporation, the former spouse of a named subscriber under such a certificate or contract is no longer entitled to coverage as an eligible dependent by reason of divorce, separate coverage for such former spouse shall be made available by the corporation on an individual nongroup basis under the following conditions:

(a) Application for such nongroup coverage shall be made to the corporation by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(b) No new evidence of insurability shall be required in connection with the application for such nongroup coverage but any health exception, limitation or exclusion applicable to said former spouse under the prior coverage may, at the option of the corporation, be carried over to the new nongroup coverage.

(c) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(d) The benefits provided under the nongroup coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the corporation to new nongroup applicants of the same age and family status.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the service corporation within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

Nonfamily type contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within 60 days from the date of birth of a newborn child.

A contract under which coverage of a dependent of a subscriber terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such subscriber for support and maintenance, not so terminate while the contract remains in force and the dependent remains in such condition, if the subscriber has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors, required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

4. Section 1 of P.L.1964, c.105 (C.17:48A-7.1) is amended to read as follows:

C.17:48A-7.1 Group contracts; issuance; description; benefits; employees defined.

1. A medical service corporation may issue to a policyholder a group contract, covering at least 10 employees or members at the date of issue, if it conforms to the following description:

(a) A contract issued to an employer or to the trustees of a fund established by one or more employers, or issued to a labor union, or issued to an association formed for purposes other than obtaining such contract, or issued to the trustees of a fund established by one or more labor unions or by one or more employers and one or more labor unions, covering employees and members of associations or labor unions.

(b) A contract issued to cover any other group which the Commissioner of Banking and Insurance (hereinafter called the commissioner) determines may be covered in accordance with sound underwriting principles.

Benefits may be provided for one or more members of the families or one or more dependents of persons who may be covered under a group contract referred to in (a) or (b) above.

Family type contracts shall provide that the services applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse from the moment of birth. The services for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide services for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the service corporation within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

Group contracts which provide for services to the subscriber but not to family members or dependents of that subscriber, other than contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide services to newly-born children of the subscriber which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, provided that application therefor and payment of the required subscription amount are made to include in said contract the coverage described in the preceding paragraph of this section within 60 days from the date of birth of a newborn child.

A contract under which coverage of such a dependent terminates at a specified age shall, with respect to an unmarried child, covered by the contract prior to attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon the covered employee or member for support and maintenance, not so terminate while the coverage of the employee or member remains in force and the dependent remains in such condition, if the employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall apply retrospectively or prospectively to require a medical service corporation to insure as a covered dependent any child with an intellectual disability or physical handicap of the applicant where the contract is underwritten on evidence of insurability based on health factors required to be set forth in the application. In such cases any contract heretofore or hereafter issued may specifically exclude such child with an intellectual disability or physical handicap from coverage.

Any group contract which contains provisions for the payment by the insurer of benefits for members of the family or dependents of a person in the insured group shall, subject to payment of the appropriate premium, provide that such family members or dependents be permitted to have coverage continued for at least 180 days after the death of the person in the insured group.

The contract may provide that the term "employees" shall include as employees of a single employer the employees of one or more subsidiary corporations and the employees, individual proprietors and partners of affiliated corporations, proprietorships and partnerships if the business of the employer and such corporations, proprietorships or partnerships is under common control through stock ownership, contract or otherwise. The contract may provide that the term "employees" shall include the individual proprietor or partners of an individual proprietorship or a partnership. The contract may provide that the term "employees" shall include retired employees. A contract issued to trustees may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship. A contract issued to the trustees of a fund established by the members of an association of employers may provide that the term "employees" shall include the employees of the association.

5. Section 20 of P.L.1985, c.236 (C.17:48E-20) is amended to read as follows:

C.17:48E-20 Coverage for newborn child.

20. a. Family type individual contracts shall provide that the coverage applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse, from the moment of birth. Coverage for newly-born children shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to provide coverage for a child, the contract may require that notification of birth of a newly-born child and the required payment must be furnished to the health service corporation within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

b. Nonfamily type individual contracts which provide for coverage to the subscriber but not to family members or dependents of that subscriber shall also provide coverage to newly-born children of the subscriber, which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital abnormalities, if application therefor and payment of the required subscription amount are made to include in the contract the coverage described in subsection a. of this section within 60 days from the date of birth of a newborn child.

6. Section 28 of P.L.1985, c.236 (C.17:48E-28) is amended to read as follows:

C.17:48E-28 Group coverage for newborn child.

28. a. Family type group coverage shall provide that the coverage applicable for children shall be payable with respect to a newly-born child of the subscriber, or his or her spouse, from the moment of birth. The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and abnormalities. If a subscription payment is required to obtain coverage for a child, the contract may require that notification of birth of a newly-born child and the required payment shall be furnished to the health service corporation within 60 days after the date of birth in order to have the coverage continue beyond that 60-day period.

b. Non-family type group coverage, other than under contracts which provide no dependent coverage whatsoever for the subscriber's class, shall also provide coverage for newly-born children of the subscriber, which coverage shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and abnormalities, if application therefor

and payment of the required subscription amount are made to include in the contract the coverage described in subsection a. of this section within 60 days from the date of birth of a newborn child.

7. N.J.S.17B:26-2 is amended to read as follows:

Form of policy; requirements.

17B:26-2. a. No such policy of insurance shall be delivered or issued for delivery to any person in this State unless:

(1) The entire money and other considerations therefor are expressed therein; and

(2) The time at which the insurance takes effect and terminates is expressed therein; and

(3) It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed 19 years and any other person dependent upon the policyholder; and

(4) The style, arrangement and over-all appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than 10-point with a lower-case unspaced alphabet length not less than 120-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); and

(5) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in sections 17B:26-3 to 17B:26-31 inclusive, are printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "exceptions," or "exceptions and reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(6) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(7) It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

b. A policy under which coverage of a dependent of the policyholder terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to attainment of age 19 and who is chiefly dependent upon such policyholder for support and maintenance, not so terminate while the policy remains in force and the dependent remains in such condition, if the policyholder has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapacity as described herein. The foregoing provisions of this paragraph shall not require an insurer to insure a dependent who is a child with an intellectual disability or physical handicap where the policy is underwritten on evidence of insurability based on health factors set forth in the application or where such dependent does not satisfy the conditions of the policy as to any requirement for evidence of insurability or other provisions of the policy, satisfaction of which is required for coverage thereunder to take effect. In any such

case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent.

c. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any optometric service which is within the lawful scope of practice of a duly licensed optometrist, the insured under such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed optometrist.

d. If any policy is issued by an insurer domiciled in this State for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the standards set forth in subsection a. of this section and in sections 17B:26-3 to 17B:26-31 inclusive.

e. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any psychological service which is within the lawful scope of practice of a duly licensed psychologist, the insured under such policy shall be entitled to reimbursement for such service, whether the said service is performed by a physician or duly licensed psychologist.

f. Notwithstanding any provision of a policy of health insurance, hereafter delivered or issued for delivery in this State, whenever such policy provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor, the insured under such policy or the chiropractor rendering such service shall be entitled to reimbursement for such service, when the said service is performed by a chiropractor. The foregoing provision shall be liberally construed in favor of reimbursement of chiropractors.

g. All individual health insurance policies which provide coverage for a family member or dependent of the insured on an expense incurred basis shall also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of that insured from the moment of birth.

(1) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(2) If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly born child and payment of the required premium must be furnished to the insurer within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

h. All individual health insurance policies which provide coverage on an expense incurred basis but do not provide coverage for a family member or dependent of the insured on an expense incurred basis shall nevertheless provide for coverage of newborn children of the insured which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application therefor and payment of the required premium are made to the insurer to include in said policy coverage the same or similar to that of the insured, described in g. (1) above 60 days from the date of a newborn child.

i. Whenever, pursuant to the provisions of an individual or group contract issued by an insurer, the former spouse of a named insured is no longer entitled to coverage as an individual dependent by reason of divorce, separate coverage for such former spouse shall be made available by the insurer on an individual non-group basis under the following conditions:

(1) Application for such non-group coverage shall be made to the insurer by or on behalf of such former spouse no later than 31 days following the date his or her coverage under the prior certificate or contract terminated.

(2) No new evidence of insurability shall be required in connection with the application for such non-group coverage but any health exception, limitation or exclusion applicable to said former spouse under the prior coverage may, at the option of the insurer, be carried over to the new non-group coverage.

(3) The effective date of the new coverage shall be the day following the date on which such former spouse's coverage under the prior certificate or contract terminated.

(4) The benefits provided under the non-group coverage issued to such former spouse shall be at least equal to the basic benefits provided in contracts then being issued by the insurer to acceptable new non-group applicants of the same age and family status.

8. N.J.S.17B:27-30 is amended to read as follows:

Dependents.

17B:27-30. Benefits of group health insurance, except benefits for loss of time on account of disability, may be provided for one or more members of the families or one or more dependents of persons who may be insured under a group policy referred to in section 17B:27-27, 17B:27-28 or 17B:27-29. Any group health insurance policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, or surgical services for members of the family or dependents of a person in the insured group must, subject to payment of the appropriate premium, permit such family members or dependents to have coverage continued for at least 180 days after the death of the person in the insured group, subject to the policy provision as to termination of coverage with respect to family members or dependents for reasons other than the death of the person in the insured group.

All group health insurance policies which provide coverage for a family member or dependent of an insured on an expense incurred basis shall also provide that the benefits applicable for children shall be payable with respect to a newly-born child of that insured from the moment of birth. The coverage for newly-born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of a specific premium is required to provide coverage for a child, the policy may require that notification of birth of a newly-born child and payment of the required premium must be furnished to the insurer within 60 days after the date of birth in order to have the coverage continue beyond such 60-day period.

All group health insurance policies which provide coverage on an expense incurred basis for the insured but do not provide coverage for a family member or dependent of the insured on an expense incurred basis, except such group policies as provide no dependent coverage whatsoever for the insured's class, shall nevertheless provide for coverage of newborn children of the insured which shall commence with the moment of birth of each child and shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, provided application and payment of the required premium are made to the insurer to include in said policy coverage for a newly-born child as described in the previous paragraph of this section within 60 days from the date of birth of a newborn child.

A policy under which coverage of a dependent of an employee or other member of the insured group terminates at a specified age shall, with respect to an unmarried child covered by the policy prior to the attainment of age 19, who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who became so incapable prior to

attainment of age 19 and who is chiefly dependent upon such employee or member for support and maintenance, not so terminate while the insurance of the employee or member remains in force and the dependent remains in such condition, if the insured employee or member has within 31 days of such dependent's attainment of the termination age submitted proof of such dependent's incapacity as described herein. The foregoing provision of this paragraph shall not require an insurer to insure a dependent who is a child with an intellectual disability or physical handicap of an employee or other member of the insured group where such dependent does not satisfy the conditions of the group policy as to any requirements for evidence of insurability or other provisions as may be stated in the group policy required for coverage thereunder to take effect. In any such case the terms of the policy shall apply with regard to the coverage or exclusion from coverage of such dependent. (cf: P.L.2010, c.50, s.10)

9. Section 16 of P.L.1997, c.146 (C.17B:27-56) is amended to read as follows:

C.17B:27-56 Incidents, certain, no imposition of preexisting condition exclusion.

16. A health insurer which offers a group health plan shall not impose a preexisting condition exclusion for the following: a. on a newborn child who, as of the last day of the 60-day period beginning with the date of birth, is covered under creditable coverage; b. on a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under creditable coverage. These provisions shall not apply to a newborn child or child who is adopted or placed for adoption after the end of the first 63-day period, during all of which the newborn child or child who is adopted or placed for adoption was not covered under any creditable coverage; or c. pregnancy as a preexisting condition.

10. Section 6 of P.L.1992, c.162 (C.17B:27A-22) is amended to read as follows:

C.17B:27A-22 Preexisting condition provisions.

6. a. No health benefits plan subject to this act shall include any provision excluding coverage for a preexisting condition regardless of the cause of the condition, provided that a preexisting condition provision may apply to a late enrollee or to any group of two to five persons if such provision excludes coverage for a period of no more than 180 days following the effective date of coverage of such enrollee, and relates only to conditions, whether physical or mental, manifesting themselves during the six months immediately preceding the enrollment date of such enrollee and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage; provided that, if 10 or more late enrollees request enrollment during any 30-day enrollment period, then no preexisting condition provision shall apply to any such enrollee.

b. In determining whether a preexisting condition provision applies to an eligible employee or dependent, all health benefits plans shall credit the time that person was covered under creditable coverage if the creditable coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage, exclusive of any applicable waiting period under such plan. A carrier shall provide credit pursuant to this provision in one of the following methods:

(1) A carrier shall count a period of creditable coverage without regard to the specific benefits covered during the period; or

(2) A carrier shall count a period of creditable coverage based on coverage of benefits within each of several classes or categories of benefits specified in federal regulation rather than the

method provided in paragraph (1) of this subsection. This election shall be made on a uniform basis for all covered persons. Under this election, a carrier shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within that class or category. A carrier which elects to provide credit pursuant to this provision shall comply with all federal notice requirements.

c. A health benefits plan shall not impose a preexisting condition exclusion for the following:

(1) A newborn child who, as of the last date of the 60-day period beginning with the date of birth, is covered under creditable coverage;

(2) A child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This provision shall not apply to coverage before the date of the adoption or placement for adoption; or

(3) Pregnancy as a preexisting condition.

11. This act shall take effect immediately.

Approved January 16, 2018.