

CHAPTER 4
ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1C-6e.

Source and Effective Date

R.2001 d.7, effective November 30, 2000.
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2005.

Chapter Historical Note

Chapter 4, Actuarial Services, was adopted and became effective prior to September 1, 1969.

Subchapter 2, Replacement of Life Insurance Policy, was adopted as R.1972 d.21, effective April 1, 1972.

Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was adopted as R.1973 d.82, effective April 15, 1973. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

Subchapter 8, Charitable Annuities, was adopted as R.1974 d.258, effective September 20, 1974. See: 6 N.J.R. 315(a), 6 N.J.R. 399(c).

Subchapter 11, Life Insurance Solicitation, was adopted as R.1976 d.329, effective October 18, 1976. See: 8 N.J.R. 336(a), 8 N.J.R. 517(a).

Subchapter 13, Group Student Health Insurance, was adopted as R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d).

Subchapter 14, Home Health Care Insurance Coverage, was adopted as R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

Subchapter 15, Alcoholism Benefits, was adopted as R.1978 d.165, effective May 22, 1978. See: 10 N.J.R. 162(a), 10 N.J.R. 257(a).

Subchapter 20, Blindness; Partial Blindness or other Physical or Mental Impairments; Unfair Discrimination, was adopted as R.1979 d.434, effective December 6, 1979. See: 11 N.J.R. 384(a), 11 N.J.R. 627(f).

Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were readopted as R.1980 d.343, effective August 5, 1980. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b).

Subchapter 21, Limited Death Benefits Forms, was adopted as R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982. See: 13 N.J.R. 18(e), 14 N.J.R. 158(d).

Pursuant to Executive Order No. 66(1978), Subchapter 15, Alcoholism Benefits, expired on May 22, 1983.

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a).

Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as R.1985 d.70, effective February 19, 1985, operative June 19, 1985. See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a).

Pursuant to Executive Order No. 66(1978), Subchapter 20, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a).

Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a).

Subchapter 24, Smoker and Nonsmoker Mortality Tables, was adopted as R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a).

Subchapter 26, Annuity Mortality Tables, was adopted as R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

Subchapter 15, Alcoholism Benefits, was adopted as R.1986 d.228, effective June 16, 1986. See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c).

Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

Subchapter 29, Homeowners Comparison Survey, was adopted as R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a).

Subchapter 31, Term Life Insurance Comparison Survey, was adopted as R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a).

Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c).

Subchapter 33, Excess Interest Reserve Adjustment, was adopted as R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c).

Subchapter 34, Long-Term Care Insurance, was adopted as R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

Subchapter 25, Medicare Supplement Interim Standards, was adopted as R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a).

Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

Petition for Rulemaking. See: 23 N.J.R. 2546(c), 23 N.J.R. 3827(a).

Subchapter 25, Medicare Supplement Interim Standards, was repealed by R.1993 d.26, effective January 4, 1993. See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Subchapter 37, Selective Contracting Arrangements of Insurers, was adopted as R.1994 d.45, effective January 18, 1994. See: 25 N.J.R. 4554(b), 26 N.J.R. 381(a).

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a).

Subchapter 30, Accelerated Death Benefits, was adopted as R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c).

Subchapter 40, Life/Health/Annuity Forms, was adopted as R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a).

Administrative correction. See: 27 N.J.R. 4728(a).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank, Subchapter 10, Expense Experience, Subchapter 32, Health Service Corporation Notice of Increased Rates, Subchapter 35, Annual Medicare Supplement Policy Survey, and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Subchapter 47, Actuarial Requirements for Flexible-Factor Policy Forms, was adopted as new rules by R.1996 d.83, effective February 5, 1996. See: 27 N.J.R. 3750(a), 28 N.J.R. 1215(a).

Subchapter 44, Standards for Contracts on a Variable Basis, was adopted as new rules by R.1996 d.149, effective March 18, 1996. See: 27 N.J.R. 3743(a), 28 N.J.R. 1546(a).

Subchapter 45, Periodic Reports, was adopted as new rules by R.1996 d.150, effective March 18, 1996. See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

Subchapter 43, Individual Annuity Contract Form Standards, was adopted as new rules by R.1996 d.181, effective April 1, 1996. See: 27 N.J.R. 3740(a), 28 N.J.R. 1885(a).

Subchapter 48, Unfair Discrimination, was adopted as new rules by R.1996 d.182, effective April 1, 1996. See: 27 N.J.R. 3756(a), 28 N.J.R. 1887(a).

Subchapter 23A, Medicare Supplement—Under 50 Coverage, and Subchapter 23B, Medicare Supplement—Age 50 through 64 Coverage were adopted as new rules by R.1996 d.195, effective April 15, 1996. See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

Subchapter 42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions, was adopted as new rules by R.1996 d.196, effective April 15, 1996. See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

Subchapter 41, Standards for Individual Life Insurance Policy Forms, was adopted as new rules by R.1996 d.197, effective April 15, 1996. See: 27 N.J.R. 3727(a), 28 N.J.R. 1992(a).

Subchapter 25, Funeral Insurance Policies, was adopted as new rules by R.1996 d.328, effective July 15, 1996. See: 28 N.J.R. 1656(a), 28 N.J.R. 3671(a).

Subchapter 49, Mandated Diabetes Benefits, was adopted as new rules by R.1997 d.86, effective February 18, 1997. See: 28 N.J.R. 4340(a), 29 N.J.R. 562(a).

Subchapter 46, Synthetic Guaranteed Investment Contract Forms, was adopted as new rules by R.1997 d.332, effective August 4, 1997. See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

Subchapter 50, Reimbursement of Inmate Health Care Costs, was adopted as new rules by R.1997 d.513, effective December 1, 1997. See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

Subchapter 52, Life Insurance Illustrations, was adopted as new rules by R.1998 d.338, effective July 6, 1998. See: 30 N.J.R. 47(a), 30 N.J.R. 2495(a).

Subchapter 32, Valuation of Life Insurance Policies, was adopted as new rules by R.1999 d.442, effective December 20, 1999 (operative January 1, 2000, except as provided in N.J.A.C. 11:4-32.6). See: 31 N.J.R. 2845(a), 31 N.J.R. 4268(c).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000. See: Source and Effective Date.

Subchapter 54, Benefit Standards for Infertility Coverage, was adopted as new rules by R.2003 d.160, effective April 21, 2003. See: 34 N.J.R. 2521(a), 35 N.J.R. 1692(b).

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APPENDIX B

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Authority

N.J.S.A. 17:1-8.1; 17:1-15e; and 17B:32B-1 et seq.

Source and Effective Date

R.2001 d.122, effective April 2, 2001.
See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

N.J.A.C. 11:4-28.7(a) All plans involved are Indemnity (including out-of-network portion of HMO POS or SCA plan without a network).

Assumptions: Indemnity Plan: 80/20 % coinsurance; primary deductible \$250; secondary deductible \$100

P = Primary S = Secondary

Plan Type*		(W)	(X)	(Y)	(Z)	(AA)
Billed Charges		1,200	1,200	1,200	1,200	1,200
P						
R	UCR (1)	1,000	1,000	1,000	1,000	1,000
I	Deductible	250	Previously Satisfied	250	Previously Satisfied	Previously Satisfied
M	Coinsurance	150	200	150	200	Previously Satisfied
A	Primary Pays	600	800	600	800	1,000
R						
Y						
S						
E	UCR (1)	900	900	900	900	900
C	Deductible	100	100	Previously Satisfied	Previously Satisfied	Previously Satisfied
O	Coinsurance	160	160	180	180	Previously Satisfied
N	Secondary Liability, if Primary	640	640	720	720	900
D	Secondary Pays (2)	600	400	600	400	200
A	Secondary Saves	40	240	120	320	700
R	Member/Insured Out of Pocket	0	0	0	0	0
Y	Provider Collects	1,200	1,200	1,200	1,200	,200

* See Below for Column description:

(W) Both P&S: Indemnity

(X) Both P&S: Indemnity (Primary Deductible satisfied)

(Y) Both P&S: Indemnity (Secondary Deductible satisfied)

(Z) Both P&S: both deducts satisfied

(AA) Both P&S: both deducts & Out of Pocket Satisfied

(1) Indemnity (includes out-of-network portion of HMO POS or SCA plan), paying on UCR basis

(2) Pays provider; or pays insured member if he/she has paid provider in form of copayment, coinsurance or deductible

inoregs/COBchart

New rule, R.2002 d.106, effective April 1, 2002 (operative January 1, 2003).
See: 33 N.J.R. 2578(a), 34 N.J.R. 1440(a).

SUBCHAPTER 29. HOMEOWNERS COMPARISON SURVEY

11:4-29.1 Purpose and scope

(a) This subchapter requires the submission of data by insurers concerning premiums on personal homeowners, tenant and/or condominium coverage to enable the Depart-

ment to compile an annual Homeowners Insurance Price Comparison Guide for use by the general public.

(b) This subchapter applies to every insurer authorized to provide and sell personal homeowners, tenant and/or condominium coverage insurance in the State of New Jersey.

11:4-29.2 Definitions

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

“Commissioner” means the Commissioner of the New Jersey Department of Banking and Insurance.

“Department” means the New Jersey Department of Banking and Insurance.

“Insurer” means a company writing homeowners, tenants and/or condominium policies in the State of New Jersey.

“Personal homeowners, tenant and/or condominium coverage” means a policy insuring the dwelling structure, contents, personal liability and medical payments in kinds and amounts set forth by the Commissioner.

Administrative change. See: 30 N.J.R. 1317(a).

11:4-29.3 Coverage option survey requirements

(a) Every insurer shall prepare and file with the Commissioner a premium survey concerning premiums charged on personal homeowners, tenant and/or condominium coverage in the following manner.

- 1. The survey shall reflect the total number of homeowners, tenant and/or condominium policies issued by each insurer as of December 31 of the reporting year.
2. Survey forms reflecting premiums for homeowners, tenants and/or condominium policies as of December 31 of the reporting year shall be filed with the Commissioner on or before January 31 of the following year.

3. Completed coverage option survey forms shall be submitted to:

New Jersey Department of Banking and Insurance
Office of Property/Casualty
20 W. State Street
PO Box 325
Trenton, NJ 08625-0325

4. In the preparation and filing of the information required by this subchapter, insurers shall use forms prescribed and provided by the Commissioner. These forms appear in Appendices A, B and C of this subchapter, which are hereby incorporated by reference as part of this subchapter.

Amended by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a). Amended by R.1998 d.86, effective February 2, 1998. See: 29 N.J.R. 4069(a), 30 N.J.R. 552(c). In (a)3, changed address. Administrative change. See: 30 N.J.R. 1317(a).

APPENDIX A

Company Name: _____

Affiliated with Group (name): _____

Price Comparison Survey

Period Ending: _____

A. Homeowners Coverage: Policy Form HO-3, frame structure built five years ago as of December 31 of the reporting year with a smoke detector, dwelling amount \$150,000, personal liability \$300,000, medical payments \$1,000, \$500.00 deductible, five miles or less to a fire station and within 1,000 feet of a hydrant or usable suction point and both dwelling and contents amounts written on a replacement cost basis. Price as of December 31, of the reporting year. All surcharges should be included in premium price.

If Your Policy Differs From Above, Please Explain: _____

List Any Dividends Your Company Offers: _____

Identify any special eligibility criteria your company may have; for example, certain groups or professional associations, referrals from present policyholders, etc. _____

Table with 2 columns: Location and Annual Premium. Lists various cities and counties with corresponding premium fields.

Location	Annual Premium
Union	* _____ *
Warren	* _____ *

As of January 1, 19____, _____ (company name) had _____ New Jersey homeowners policies in force.

As of December 31, 19____, _____ (company name) had _____ New Jersey homeowners policies in force.

Signature of Officer or Senior Manager

Phone Number: _____

PLEASE RETURN TO:

NEW JERSEY DEPARTMENT OF BANKING
AND INSURANCE
OFFICE OF PROPERTY/CASUALTY
20 WEST STATE STREET
PO BOX 325
TRENTON, NJ 08625-0325

Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Amended by R.1998 d.86, effective February 2, 1998.
See: 29 N.J.R. 4069(a), 30 N.J.R. 552(c).
Changed deductible to \$500.00 and changed address.
Administrative change.
See: 30 N.J.R. 1317(a).

APPENDIX B

Company Name: _____

Affiliated with Group (name): _____

Price Comparison Survey

Period Ending: _____

B. Tenant Coverage: Policy Form HO-4, contents amount \$20,000, personal liability \$300,000, medical payments \$1,000, smoke detector, \$500.00 and five miles or less to a fire station and within 1,000 feet of a hydrant or useable suction point with contents amount written on a replacement cost basis. Price as of December 31, of the reporting year. All surcharges should be included in premium price.

If Your Policy Differs From Above, Please Explain: _____

List Any Dividends Your Company Offers: _____

Identify any special eligibility criteria your company may have; for example, certain groups or professional associations, referrals from present policyholders, etc. _____

Location	Annual Premium	
1. Cities		
City of	County of	
Bayonne	Hudson	* _____ *
Camden	Camden	* _____ *
Clifton	Passaic	* _____ *
E. Orange	Essex	* _____ *
Elizabeth	Union	* _____ *
Jersey City	Hudson	* _____ *
Newark	Essex	* _____ *
Passaic	Passaic	* _____ *
Paterson	Passaic	* _____ *
Trenton	Mercer	* _____ *
Woodbridge	Middlesex	* _____ *
2. Other than Cities		
County of		
Atlantic	* _____ *	
Bergen	* _____ *	
Burlington	* _____ *	
Camden	* _____ *	
Cape May	* _____ *	
Cumberland	* _____ *	
Essex	* _____ *	
Gloucester	* _____ *	
Hudson	* _____ *	
Hunterdon	* _____ *	
Mercer	* _____ *	
Middlesex	* _____ *	
Monmouth	* _____ *	
Morris	* _____ *	
Ocean	* _____ *	
Passaic	* _____ *	
Salem	* _____ *	
Somerset	* _____ *	
Sussex	* _____ *	
Union	* _____ *	
Warren	* _____ *	

As of January 1, 19____, _____ (company name) had _____ New Jersey tenant policies in force.

As of December 31, 19____, _____ (company name) had _____ New Jersey tenant policies in force.

Signature of Officer or Senior Manager

Phone Number: _____

PLEASE RETURN TO:

“Religious employer” means an employer that is a church, convention or association of churches, or any group or entity that is operated, supervised or controlled by or in connection with a church, convention or association of churches, as defined in 26 U.S.C. § 3121(w)(3)(A) (Federal Insurance Contributions Act) and that qualifies as a tax-exempt organization under 26 U.S.C. § 501(c)(3) (Internal Revenue Code, Exempt Organizations).

“Sexual intercourse” means sexual union between a male and a female.

“Surrogate” means a woman who carries an embryo that was formed from her own egg inseminated by the sperm of a designated sperm donor.

“Zygote” means a fertilized egg before cell division begins.

“Zygote intrafallopian tube transfer” or “ZIFT” means a procedure whereby an egg is fertilized in vitro, and the zygote is transferred to the fallopian tube at the pronuclear stage before cell division takes place.

11:4-54.3 Infertility coverage provided to the same extent as other pregnancy-related procedures

(a) A carrier shall not impose a separate copayment, coinsurance, deductible, dollar maximum, visit maximum or procedure maximum on any infertility treatment other than limiting infertility coverage to four completed egg retrievals per lifetime of the covered person.

(b) A carrier shall not impose a separate preauthorization notice or other utilization management requirement on infertility treatment. (For example, if a carrier requires all hospitalizations or all surgeries to be preauthorized, and a particular infertility treatment is to be performed during a hospitalization or is a surgical procedure, the carrier may require preauthorization of the treatment. But a carrier shall not require that all infertility treatments be preauthorized.)

(c) A carrier may limit benefits required to be provided pursuant to this subchapter to services performed at facilities that conform to standards established by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists. Carriers shall not impose any additional standards in the group policy or contract and in the certificate or evidence of coverage applicable to fertility services on facilities or other providers.

11:4-54.4 Required benefits

(a) Infertility coverage shall include, but is not limited to, payment of benefits for the following services and procedures recognized by the American Society for Reproductive Medicine or the American College of Obstetricians and Gynecologists:

1. Artificial insemination with no limit as to the number of cycles;
2. Assisted hatching;
3. Diagnosis and diagnostic tests;
4. Fresh and frozen embryo transfer;
5. Four completed egg retrievals per lifetime of the covered person;
 - i. Where a live donor is used in the egg retrieval, the medical costs of the donor shall be covered until the donor is released from treatment by the reproductive endocrinologist;
 - ii. Egg retrievals where the cost was not covered by any carrier shall not count in determining whether the four completed egg retrieval limit has been met;
6. Gamete intrafallopian transfer and zygote intrafallopian transfer;
7. Intracytoplasmic sperm injections;
8. In vitro fertilization, including in vitro fertilization using donor eggs and in vitro fertilization where the embryo is transferred to a gestational carrier or surrogate;
9. Medications, including injectible infertility medications, even if the contract or policy does not provide prescription drug benefits. Where a contract or policy provides both prescription drug and medical and hospital benefits, infertility drugs shall be covered under the prescription drug coverage;
10. Ovulation induction; and
11. Surgery, including microsurgical sperm aspiration.

11:4-54.5 Permissible benefit exclusions

(a) Following are the only permissible exclusions from the infertility benefit requirements of this subchapter:

1. Reversal of voluntary sterilization.
 - i. Coverage for infertility services provided to partners of persons who have successfully reversed sterilization may not be excluded provided that the partner is infertile as defined by P.L. 2001, c.236 and this subchapter;
2. Payment for medical services rendered to a surrogate for purposes of childbearing where the surrogate is not covered by the carrier’s policy or contract;
3. Costs associated with cryopreservation and storage of sperm, eggs and embryos;
4. Nonmedical costs of an egg or sperm donor. Medical costs of donors, including office visits, medications, laboratory and radiological procedures and retrieval, shall be covered until the donor is released from treatment by the reproductive endocrinologist;

5. Infertility treatments that are experimental or investigational in nature;

6. Ovulation kits and sperm testing kits and supplies;

7. In vitro fertilization, gamete intrafallopian tube transfer, and zygote intrafallopian tube transfer for persons who have not used all reasonable less expensive and medically appropriate treatments for infertility, who have exceeded the limit of four covered completed egg retrievals, or who are 46 years of age or older; and

8. Group policies, contracts, riders and endorsements that provide hospital or medical benefits, other than policies or contracts that provide prescription drug benefits only, may provide that infertility medication benefits are excluded if infertility medication benefits are provided under another group health insurance policy or contract issued to the same policyholder or contractholder.

11:4-54.6 Religious employer exclusions

(a) A carrier shall exclude coverage for in vitro fertilization, embryo transfer, artificial insemination, zygote intrafallopian transfer, gamete intrafallopian transfer, and intracytoplasmic sperm injection at the request of a religious employer only if the required coverage is contrary to the religious employer's bona fide religious tenets.

(b) A carrier that issues a policy or contract containing a religious employer exclusion shall provide written notice of such exclusion to each prospective insured or covered person. Such notice shall appear in not less than 10-point type in the certificate or evidence of coverage, the covered person's application or enrollment form, and all sales and marketing materials.

11:4-54.7 Effect on previously filed forms

Forms previously filed or approved by the Commissioner pursuant to N.J.S.A. 17B:27-49 and 26:2J-43 that contain provisions not in compliance with this subchapter shall be deemed withdrawn and shall not be delivered, issued, executed or renewed.

SUBCHAPTER 55. (RESERVED)

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

Authority

N.J.S.A. 17:1-8.1 and 15e; 17B:27C-1 et seq.; and 17B:27A-49.

Source and Effective Date

R.2004 d.212, effective June 7, 2004.
See: 35 N.J.R. 3530(a), 36 N.J.R. 2907(a).

Subchapter Historical Note

Subchapter 56, Self-funded Multiple Employer Welfare Arrangements and Insured Multiple Employer Arrangements, was adopted as R.2004 d.212, effective June 7, 2004. See: Source and Effective Date.

11:4-56.1 Purpose and scope

(a) This subchapter implements N.J.S.A. 17B:27C-1 et seq. by establishing rules for the registration, regulation and reporting of self-funded and partially self-funded multiple employer welfare arrangements (self-funded MEWAs). This subchapter also implements N.J.S.A. 17B:27A-49 by clarifying the requirement that insured multiple employer arrangements (MEAs) notify the Commissioner of certain information on an annual basis.

(b) This subchapter applies to self-funded and partially self-funded multiple employer welfare arrangements as defined in 29 U.S.C. § 1002(40), other than governmental plans as defined in 29 U.S.C. § 1002(32) and church plans as defined in 29 U.S.C. § 1002(33), that provide a health benefit plan or plans which cover the employees of at least one employer that is either domiciled in New Jersey or has its principal headquarters or principal administrative office located in New Jersey. This subchapter also applies to carriers providing health benefits coverage, stop-loss coverage or administrative services to multiple employer arrangements as defined at N.J.S.A. 17B:27A-17.

11:4-56.2 Definitions

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

“Administrator” means a person, partnership, corporation or other legal entity engaged by a self-funded MEWA, as defined in this section, to act as executive director to carry out the policies established by the trustees and to otherwise administer and provide day-to-day management of the health benefit plans.

“Association” means a group of 100 or more persons organized and maintained in good faith for purposes other than that of obtaining insurance, in active existence for more than one year, having a constitution and by-laws that provide that: the association holds regular meetings not less than annually to further the purposes of the members; except for credit unions, the association collects dues or solicits contributions from members; and the members have voting privileges and representation on the governing board and committees.