

Subchapter 11, Life Insurance Solicitation, was repealed and Subchapter 11, Life Insurance Disclosure, was adopted as new rules by R.2008 d.71, effective April 7, 2008 (operative July 6, 2008). See: 39 N.J.R. 4065(a), 40 N.J.R. 1882(a).

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. NEW JERSEY INSOLVENT HEALTH MAINTENANCE ORGANIZATION ASSISTANCE ASSOCIATION

- 11:4-1.1 Purpose and scope
- 11:4-1.2 Definitions
- 11:4-1.3 Establishment of Association and Fund
- 11:4-1.4 Relief
- 11:4-1.5 Application procedures and filing format
- 11:4-1.6 Informational filing requirements
- 11:4-1.7 Confidentiality of request for relief
- 11:4-1.8 Disposition of request for relief
- 11:4-1.9 Rates
- 11:4-1.10 Penalties

SUBCHAPTER 2. LIFE INSURANCE AND ANNUITIES REPLACEMENT

- 11:4-2.1 Purpose and scope
- 11:4-2.2 Definitions
- 11:4-2.3 Duties of producers
- 11:4-2.4 Duties of replacing insurers
- 11:4-2.5 Duties of insurers that use producers
- 11:4-2.6 Duties of the existing insurer
- 11:4-2.7 Duties of insurers with respect to direct response solicitations
- 11:4-2.8 Violations and penalties
- 11:4-2.9 Separability

APPENDIX A

APPENDIX B

APPENDIX C

SUBCHAPTER 3. COUPON POLICIES AND POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-3.1 Payments
- 11:4-3.2 Gross premium shown
- 11:4-3.3 Gross premium regarding additional insurance
- 11:4-3.4 Coupons
- 11:4-3.5 Guaranteed annual endowments
- 11:4-3.6 Severability
- 11:4-3.7 Effective date

SUBCHAPTER 4. PASSBOOKS USED IN CONNECTION WITH COUPON POLICIES OR POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-4.1 General provisions
- 11:4-4.2 Unfair practice
- 11:4-4.3 Scope
- 11:4-4.4 Severability
- 11:4-4.5 Effective date

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. MINIMUM RESERVE STANDARDS FOR INDIVIDUAL AND GROUP HEALTH INSURANCE CONTRACTS

- 11:4-6.1 Purpose and scope
- 11:4-6.2 Definitions
- 11:4-6.3 Claim reserves—general requirements
- 11:4-6.4 Claim reserves—minimum standards for claim reserves
- 11:4-6.5 Claim reserves—claim reserve methods

- 11:4-6.6 Premium reserves—general requirements
- 11:4-6.7 Premium reserves—minimum standards for unearned premium reserves
- 11:4-6.8 Premium reserves—premium reserve methods
- 11:4-6.9 Contract reserves—general requirements
- 11:4-6.10 Contract reserves—minimum standards for contract reserves
- 11:4-6.11 Contract reserves—alternative valuation methods and assumptions generally
- 11:4-6.12 Tests for adequacy and reasonableness of contract reserves
- 11:4-6.13 Reinsurance
- 11:4-6.14 Specific standards for morbidity for valuation of specified individual contract health insurance benefits
- 11:4-6.15 Specific standards for morbidity for valuation of specified group contract health insurance benefits
- 11:4-6.16 Specific standards for interest
- 11:4-6.17 Specific standards for mortality
- 11:4-6.18 Reserves for waiver of premium

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

- 11:4-7.1 Purpose and scope
- 11:4-7.2 Definitions
- 11:4-7.3 Filing requirements
- 11:4-7.4 Premium charges
- 11:4-7.5 Approval of applications

APPENDIX EXHIBITS A THROUGH C

SUBCHAPTER 8. CHARITABLE ANNUITIES

- 11:4-8.1 Purpose
- 11:4-8.2 Definitions
- 11:4-8.3 Application for a special permit
- 11:4-8.4 Forms of agreement
- 11:4-8.5 Annuity rates
- 11:4-8.6 Surplus and reserves
- 11:4-8.7 Compliance with investment requirements
- 11:4-8.8 Annual report
- 11:4-8.9 Effect on previously filed forms
- 11:4-8.10 Separability of provisions
- 11:4-8.11 Penalties

SUBCHAPTER 9. PERSONAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

- 11:4-9.1 Purpose and scope
- 11:4-9.2 Definitions
- 11:4-9.3 Prospective loss cost filing requirements for rating organizations and advisory organizations
- 11:4-9.4 Prospective loss costs filing requirements for insurers
- 11:4-9.5 Penalties

APPENDIX A

APPENDIX B

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. LIFE INSURANCE DISCLOSURE

- 11:4-11.1 Purpose and scope
- 11:4-11.2 Definitions
- 11:4-11.3 Duties of insurers
- 11:4-11.4 General regulations
- 11:4-11.5 Failure to comply/penalties
- 11:4-11.6 Separability
- 11:4-11.7 Effective date

APPENDIX A. LIFE INSURANCE BUYER'S GUIDE

SUBCHAPTER 12. STUDENT LIFE INSURANCE

- 11:4-12.1 Student life insurance solicitation

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

- 11:4-13.1 Scope
- 11:4-13.2 Definitions
- 11:4-13.3 Prohibited provisions

SUBCHAPTER 14. HOME HEALTH CARE INSURANCE COVERAGE

- 11:4-14.1 Scope
- 11:4-14.2 Definitions
- 11:4-14.3 Home health care benefits required
- 11:4-14.4 Exclusions
- 11:4-14.5 Effective date

SUBCHAPTER 15. ALCOHOLISM BENEFITS

- 11:4-15.1 Scope
- 11:4-15.2 Benefits
- 11:4-15.3 Exclusions

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

- 11:4-16.1 Purpose
- 11:4-16.2 Applicability and scope
- 11:4-16.3 Effective date
- 11:4-16.4 Policy definitions
- 11:4-16.5 Prohibited policy provisions
- 11:4-16.6 Minimum standards for benefits
- 11:4-16.7 Application forms
- 11:4-16.8 Required disclosure provisions
- 11:4-16.9 Forms submission requirements
- 11:4-16.10 Separability
- 11:4-16.11 Penalties

APPENDIX A

SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION

- 11:4-17.1 Purpose
- 11:4-17.2 Applicability and scope
- 11:4-17.3 Definitions
- 11:4-17.4 Unfair and deceptive acts
- 11:4-17.5 Replacement
- 11:4-17.6 Complaint record to be maintained
- 11:4-17.7 Penalties
- 11:4-17.8 Separability
- 11:4-17.9 Effective date

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

- 11:4-18.1 Purpose
- 11:4-18.2 Applicability and scope
- 11:4-18.3 Definitions
- 11:4-18.4 Rate submission requirements
- 11:4-18.5 Loss ratio standards
- 11:4-18.6 Annual review of calendar year experience data on filed individual health insurance policy forms
- 11:4-18.7 Rate manual
- 11:4-18.8 Separability
- 11:4-18.9 Penalties
- 11:4-18.10 Compliance

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

- 11:4-19.1 Purpose
- 11:4-19.2 Scope
- 11:4-19.3 Second surgical opinions
- 11:4-19.4 Maternity benefits option

SUBCHAPTER 20. BLINDNESS; PARTIAL BLINDNESS OR OTHER PHYSICAL OR MENTAL IMPAIRMENTS; UNFAIR DISCRIMINATION

- 11:4-20.1 Purpose
- 11:4-20.2 Unfair discriminatory acts or practices

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

- 11:4-21.1 Purpose; scope
- 11:4-21.2 Definitions
- 11:4-21.3 General requirements
- 11:4-21.4 Severability

SUBCHAPTER 22. INDIVIDUAL LIFE INSURANCE: USE OF GENDER BLENDED MORTALITY TABLES

- 11:4-22.1 Purpose
- 11:4-22.2 Definitions
- 11:4-22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.4 Construction of Gender Blended Smoker and Non-smoker Mortality Tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.5 Use of gender blended mortality tables in the non-Norris market
- 11:4-22.6 Effect on previously filed forms
- 11:4-22.7 Unfair discrimination
- 11:4-22.8 Separability

APPENDIX A

APPENDIX B

SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE

- 11:4-23.1 Purpose
- 11:4-23.2 Applicability and scope
- 11:4-23.3 Definitions
- 11:4-23.4 Policy definitions and terms
- 11:4-23.5 Policy provisions
- 11:4-23.6 General minimum benefit standards
- 11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993
- 11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993
- 11:4-23.9 Open enrollment
- 11:4-23.10 Standards for claims payment
- 11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation
- 11:4-23.12 Guaranteed issue for eligible persons
- 11:4-23.13 Filing requirements for policies, certificates and premium rates, including procedures for review and intervention by the Public Advocate, Division of Rate Counsel
- 11:4-23.14 Compensation arrangements
- 11:4-23.15 Required disclosure provisions
- 11:4-23.16 Requirements for application forms and replacement coverage
- 11:4-23.17 Filing requirements for advertising
- 11:4-23.18 Standards for marketing
- 11:4-23.19 Appropriateness of recommended purchase and excessive coverage
- 11:4-23.20 Reporting of multiple policies
- 11:4-23.21 Addresses for submissions for filing
- 11:4-23.22 Penalties
- 11:4-23.23 Severability

2. For purposes of the definition of “insolvency” or “insolvent,” “liabilities” shall include, but not be limited to, reserves required by law or by regulations of the New Jersey Department of Banking and Insurance (Department) or specific requirements imposed by the Commissioner of the Department upon a carrier at the time of admission or subsequent thereto.

“Insured” means any applicant provided coverage by a carrier.

“Medicare Advantage plan” means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 of Title IV, Subtitle A, Chapter 1 of P.L. 105-33 (42 U.S.C. § 1395w-28), and includes:

1. Coordinated care plans which provide health care services, including, but not limited to, health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations and preferred provider organization plans;
2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and
3. Medicare Advantage private fee-for-service plans.

“Medicare supplement policy” means a group or individual policy which is advertised, marketed or designed primarily as, or is otherwise held out to be a supplement to reimbursements under Medicare, other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.), or a contract or policy issued under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1). This term does not include a policy or certificate of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, of the labor organization. “Medicare supplement policy” does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under § 1833(a)(1)(A) of the Social Security Act.

“Months exposed” means, for a given calendar period, the sum of the number of months an insured was covered for all insureds during that period.

“Policy” shall mean any policy, contract, certificate or other document which sets forth or summarizes the essential features of the coverage issued to an individual or group by a carrier, for the purpose of providing Medicare supplement coverage, including any such policy issued pursuant to a conversion privilege to an individual 65 years of age or older,

except as otherwise provided in this subchapter or Federal law.

“Policy form” means the form on which a policy is delivered or issued for delivery by a carrier.

“Secretary” means the Secretary of the United States Department of Health and Human Services.

Amended by R.1991 d.345, effective July 1, 1991.
See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted “Medicare supplement” in “applicant” 1.

Deleted “Medicare supplement subscriber contract”, “hospital or medical service benefits,”; added “policy”, “coverage” in “applicant” 2.

Deleted “applicant” 3.

Deleted “:1. Any”, “Medicare Supplement”, “policy”; added “or other document which sets forth or summarizes the essential features of the coverage”, “certificate or other document” in “Certificate” 1.

Deleted “Certificate” 2.

Added “Coverage”.

Deleted “:1.A”, “accident and sickness insurance”, “:i.A”; deleted 1ii and 1iii in “Medicare supplement policy”.

Deleted “Medicare supplement policy” 2.

Added “Policy”.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Added definitions for aggregate loss ratio, anticipated loss ratio, carrier, certificate form and policy form; deleted definition of, and references to, insurer.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended “Medicare supplement policy”.

Emergency amendment R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Inserted “Bankruptcy”, “Employer welfare benefit plan”, “Insolvency” or “insolvent”, “Medicare+Choice plan” and “Secretary”.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Inserted “Continuous period of creditable coverage” and “Creditable coverage”.

Amended by R.2004 d.246, effective July 6, 2004.

See: 35 N.J.R. 2562(a), 36 N.J.R. 3292(a).

Added “Months exposed”.

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Substituted “Medicare Advantage” for “Medicare+Choice” throughout; added the last sentence in the definition of “Medicare supplement policy”.

11:4-23.4 Policy definitions and terms

(a) No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

1. “Accident,” “accidental injury,” or “accidental means” shall be defined to employ “result” language and shall not include words which establish an accidental means test or use words such as “external, violent, visible wounds” or similar words of description or characterization.

i. "Injury" shall not be defined more restrictively than as a bodily injury sustained by the covered person as a result of an accident, which injury is the direct cause of the loss, independent of disease, bodily infirmity or any other cause, and which occurs while coverage is in force.

ii. The definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, mandatory motor vehicle no-fault plan, unless prohibited by law.

2. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

3. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined by the Medicare program.

4. "Health care expenses" means, for purposes of N.J.A.C. 11:4-23.11, expenses of health maintenance organizations which expenses are associated with the delivery of health care services and are analogous to incurred losses of insurers. Expenses shall not include the following costs:

- i. Home office and overhead costs;
- ii. Advertising costs;
- iii. Commissions and other acquisition costs;
- iv. Taxes;
- v. Capital costs;
- vi. Administrative costs; and
- vii. Claims processing costs.

5. "Hospital" may be defined in relation to its status, facilities, and available services or to reflect accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined by the Medicare program.

6. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

7. "Medicare eligible expense" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

8. "Physician" shall not be defined more restrictively than as defined by the Medicare program.

9. "Preexisting condition" shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

10. "Sickness" shall not be defined more restrictively than a sickness or disease which causes loss commencing while the insurance or coverage is in force and which is not excluded under a preexisting condition limitation. The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

11. "Totally disabled" shall not be defined more restrictively than as:

- i. An injury or sickness that continuously confines an individual in a hospital or skilled nursing facility; or
- ii. A continuous disability resulting from an injury or sickness not requiring confinement of an individual in a hospital or skilled nursing facility, but which a physician certifies as preventing that individual from engaging in the normal activities of a person of like age and sex in good health.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance", "or individual or group subscriber contract", "Supplement", "or subscriber contract" in (a).

Deleted "the definition of injury", "an accidental", "insurance or service corporation"; added "Injury", "defined", "as a result of an accident", "injury" in (a)li.

Deleted ", or injuries occurring while the covered person is engaged in any activity pertaining to any trade, or business, employment, or occupation for wage or profit" in (a)lii.

Deleted "or hospital or medical service corporations", "may", "as are applicable to Medicare claims"; added "shall", "as are applicable to Medicare claims" in (a)lii6.

Deleted "or hospital or medical service corporation" in (a)lii8 and 9.

Added (a)lii12.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Added definition for health care expenses and references to Medicare standards.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

In (a)4, added ", for purposes of N.J.A.C. 11-4-23.11," following "means"; in (a)7, added "Part A and B" following "by Medicare".

11:4-23.5 Policy provisions

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy if the policy or certificate contains limitations or exclusions that are more restrictive than those of Medicare, except with respect to preexisting condition limitations.

(b) No Medicare supplement policy or certificate shall provide benefits which duplicate benefits provided by Medicare.

(c) No Medicare supplement policy or certificate shall use waiver endorsements or riders to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(d) Subject to N.J.A.C. 11:4-23.6(b)4 and 7, 23.6(c), 23.7(c) and 23.8(b), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006 shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

(e) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(f) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

1. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

2. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "Medicare Supplement", "may", "such policy"; added "shall", "as a Medicare supplement policy", "it" in (a).

Added "outside the United States" in (a)10.

Changed "Supplement" to "supplement" and "may" to "shall" in (b), (c) and (d); added "endorsements or riders" to (d).

Added (e).

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule amended to conform to Medicare standards.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Added (d) through (f).

11:4-23.6 General minimum benefit standards

(a) No policy or certificate shall be advertised, solicited, or issued for delivery in this State as a Medicare supplement policy if it does not meet the minimum standards contained in this section.

(b) The following general standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this subchapter.

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred as a result of a preexisting condition after six months from the effective date of coverage, nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)9.

2. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors, if any, in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.11.

4. A Medicare supplement policy or certificate shall not:

- i. Provide for termination of coverage of an eligible spouse because of termination of coverage of the insured other than for nonpayment of premium; or

- ii. Provide for termination of a covered persons' coverage by the carrier solely on the grounds of age or deterioration of health.

5. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy or certificate was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the covered person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining continuous loss.

6. Existing Medicare supplement policies and certificates shall be appropriately amended or endorsed to eliminate benefit duplications with Medicare which are caused by Medicare benefit changes. Any riders or endorsements shall specify the benefits deleted, or shall otherwise result in a clear description of the Medicare supplement benefits provided by the policy. Such riders or endorsements shall be submitted for filing by the Commissioner.

7. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subchapter.

(c) A carrier shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. With

respect to terminations of group policies, or membership in a group, the following standards shall apply:

1. If a group policyholder terminates the group Medicare supplement policy without replacing that policy as provided in (c)3 below, the carrier shall offer individuals covered under group policies at least the following two coverage choices:

i. An individual guaranteed renewable Medicare supplement policy which provides for continuation of the benefits contained in the group policy; and

ii. An individual Medicare supplement policy which provides only benefits that otherwise are required to meet N.J.A.C. 11:4-23.8.

2. If membership in a group is terminated, the carrier shall:

i. Offer the individual whose membership is terminated the conversion opportunities described in (c)1 above; or

ii. Offer the individual whose membership is terminated continuation of coverage under the group policy, but only at the option of the group policyholder.

3. If a group policyholder replaces one group Medicare supplement policy by another group Medicare supplement policy, the carrier issuing the replacement coverage shall offer coverage to all persons who were covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusions for preexisting conditions that would have been covered under the group policy which was replaced.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Added (b)6,-10.; (c)1 and renumbered (c)1.-4. as i.-iv.; added (c)2.

Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (b)7: revised internal references to chapter.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Deleted "group insurance", "For individual or group subscriber contract may", "which"; added "shall", "if it" in (a).

Added "nor shall a preexisting condition be defined more restrictively than as set forth at N.J.A.C. 11:4-23.4(a)11." in (b) with stylistic change.

Added "in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-23.8" in (b)3.

Deleted ", or subscriber" in (b)4i.

Deleted "For hospital or medical service corporation" in (b)4ii.

Deleted (b)6, 7, 9, 10.

Recodified existing (b)8 as 6; deleted "commissioner for filing with 45 days after the effective dates of Medicare benefit changes".

Added (c) and (d).

Recodified existing (c) as (e); recodified existing (c)1i, ii, iii, iv as (e)2, 3, 4, 6.

Deleted "For policies issued prior to January 1, 1989;"; added "coverage for either all or none of the Medicare Part A in-patient hospital deductible amount;" in recodified (e)1.

Added (e)5, 7.

Deleted "of \$200.00 of such expenses and to a maximum calendar year benefit of at least \$5,000.;" added "regardless of hospital confinement", "amount equal to the Medicare Part B" in recodified (e)6.

Deleted (c)2.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

General standards for policies and certificates delineated, references to insurer changed to "carrier."

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

In (b), added the last sentence in 5, added 7.

11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993

(a) All policies delivered or issued for delivery in this State prior to January 4, 1993, and all certificates delivered or issued for delivery in this State on or after July 15, 1991 but prior to January 4, 1993 as a Medicare supplement policy or certificate, shall meet the minimum standards set forth at N.J.A.C. 11:4-23.6 in addition to the minimum standards set forth below. The standards of N.J.A.C. 11:4-23.6 and those below are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(b) Benefit conversion requirements for the transition of policy compliance between the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360) and the Medicare Catastrophic Coverage Repeal Act of 1989 (P.L. 101-234) are as follows:

1. Effective January 1, 1990, no Medicare supplement policy in force in this State shall contain benefits provided by Medicare.

2. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

3. For Medicare supplement policies subject to the minimum standards adopted by this State pursuant to the Medicare Catastrophic Coverage Act of 1988, and all policies and certificates delivered or issued for delivery on or after April 16, 1990 but prior to January 4, 1993, the minimum benefit standards for Medicare supplement policies are:

i. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

ii. Coverage of the Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

iii. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges to the extent not covered by Medicare during use of Medicare's lifetime hospital inpatient reserve days;

iv. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible

expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

v. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations or already paid for under Part B;

vi. Coverage of Part B Medicare eligible expenses to the extent not covered by Medicare regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible;

vii. Coverage under Medicare Part B for the reasonable cost of the first three pints (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(c) Medicare supplement policies shall be guaranteed renewable.

New Rule, R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on Standards for claims payment recodified to 23.10.

11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993

(a) No policy or certificate shall be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy on or after January 4, 1993 unless it complies with the standards of N.J.A.C. 11:4-23.6 and the benefit standards set forth below.

(b) Medicare supplement policies shall be guaranteed renewable.

(c) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act (42 U.S.C. § 1396-v-end), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date that the individual becomes entitled to that assistance.

1. If suspension occurs and if the policyholder or certificateholder loses entitlement to Title XIX medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of the termination of the entitlement) if the policyholder or certificateholder provides notice of their loss of the entitlement to the Title

XIX assistance within 90 days after the date of that loss and the policyholder or certificateholder pays the premium attributable to the period subsequent to the date of the termination of the entitlement.

2. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for any period that may be provided by Federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act, 42 U.S.C. § 426(b), and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act, 42 U.S.C. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period from the date of the termination of their enrollment in the group health plan.

3. Reinstitution of coverage as described in (c)1 and 2 above shall:

i. Not impose any waiting period with respect to treatment of preexisting conditions;

ii. Provide for resumption of coverage that is substantially equivalent to the coverage that was in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

iii. Provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

(d) All carriers delivering or issuing for delivery in this State Medicare supplement policies or certificates of group Medicare supplement policies shall offer to all applicants a policy or certificate providing only the core benefits defined at (g) below. A policy or certificate providing only core benefits shall be designated as standardized Medicare supplement benefit plan A.

(e) Carriers may offer to all applicants policies or certificates providing the core benefits and additional benefits defined at (g) below. Only those additional benefits defined at (g) below may be included in Medicare supplement policies or certificates delivered or issued for delivery in this State. Policies or certificates providing additional benefits shall be structured and designated as follows:

1. Standardized Medicare supplement benefit plan B shall provide:

- i. The Core Benefit; and
- ii. The Medicare Part A Deductible benefit.

2. Standardized Medicare supplement benefit plan C shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The At-Home Recovery Benefit.

4. Standardized Medicare supplement benefit Plan E shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- v. The Preventive Medical Care benefit.

5. Standardized Medicare supplement benefit Plan F shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Medicare Part B Deductible benefit;
- v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit; and
- vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

6. Standardized Medicare supplement benefit high deductible plan F shall include 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible, and shall provide: the Core

Benefit; the Medicare Part A Deductible benefit; the Skilled Nursing Facility Care benefit; the Medicare Part B Deductible benefit; the One Hundred Percent (100%) of the Medicare Part B Excess Charges benefit; and the Medically Necessary Emergency Care in a Foreign Country benefit. The annual high deductible plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan F policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan F deductible shall be \$1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

7. Standardized Medicare supplement benefit plan G shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Eighty Percent (80%) of the Medicare Part B Excess Charges benefit;
- v. The Medically Necessary Emergency Care in a Foreign Country benefit; and
- vi. The At-Home Recovery Benefit.

8. Standardized Medicare supplement benefit plan H shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The Basic Outpatient Prescription Drug Benefit. The Basic Outpatient Prescription Drug Benefit shall not be included in a Medicare supplement plan sold after December 31, 2005; and
- v. The Medically Necessary Emergency Care in a Foreign Country benefit.

9. Standardized Medicare supplement benefit plan I shall provide:

- i. The Core Benefit;
- ii. The Medicare Part A Deductible benefit;
- iii. The Skilled Nursing Facility Care benefit;
- iv. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;

transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing of bandages or other dressings.

v. A care provider shall be a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or a licensed nurses registry.

vi. Any place used by the insured as a place of residence shall be the insured's home, provided that such place would qualify as a residence for home health care services under Medicare. A hospital or skilled nursing facility shall not be considered the insureds' place of residence.

vii. An at-home recovery visit shall be that period of a visit required to provide at-home recovery care. The duration of any such visit shall not be limited, but each consecutive four hours in a 24 hour period of services provided by a care provider shall constitute one visit for purposes of this section.

2. "Basic Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 calendar year deductible and a maximum per calendar year benefit per insured of \$1,250. The basic outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

3. "Core Benefit" means coverage of:

i. Medicare Part A eligible expenses for hospitalization from the 61st day through the 90th day in any Medicare benefit period, to the extent not covered by Medicare;

ii. Medicare Part A eligible expenses for hospitalization for each Medicare lifetime inpatient reserve day used, to the extent not covered by Medicare;

iii. One hundred percent of Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days, to be paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment. The provider shall accept the carrier's payment as payment in full and may not bill the insured for any balance;

iv. The reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined by Federal regulations) under Medicare Parts A and B, unless replaced in accordance with Federal regulation; and

v. The coinsurance amount or, in the case of hospital outpatient department services paid under a

prospective payment system, the copayment amount of Medicare Part B eligible expenses (generally 20 percent of the approved amount; 50 percent of the approved charges for outpatient psychiatric services), regardless of hospital confinement, subject to the Medicare Part B deductible.

4. "Eighty Percent (80%) of the Medicare Part B Excess Charges" means coverage for 80 percent of the difference between the Medicare-approved Part B charge and the actual Medicare Part B charge billed, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

5. "Extended Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a \$250.00 deductible per calendar year, and a maximum per calendar year per insured benefit of \$3,000. The extended outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

6. "Innovative Benefits" means benefits that are in addition to the benefits specified for standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J, that are appropriate to Medicare supplement insurance and do not duplicate any benefit provided by Medicare, and that are otherwise unavailable, cost effective, and offered in a manner consistent with simplification of Medicare supplement policies. No carrier shall include an Innovative Benefit in a policy or certificate offered for delivery in this State without the prior approval of the Commissioner.

7. "Medically Necessary Emergency Care in a Foreign Country" means coverage of 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if received in the United States, and which care began during the first 60 consecutive days of each trip outside the United States, to the extent billed charges are not covered by Medicare, and subject to a calendar year deductible of \$250.00 and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

8. "Medicare Part A Deductible" means coverage of all of the Medicare Part A inpatient hospital deductible amount per benefit period.

9. "Medicare Part B Deductible" means coverage of all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

10. "One Hundred Percent (100%) of the Medicare Part B Excess Charges" means coverage for all of the difference between the Medicare Part B approved charge and the actual Medicare Part B billed charge, up to but not

exceeding any charge limitation established by the Medicare program or this State's law, if any.

11. "Preventive Medical Care Benefit" means coverage of the following services not otherwise covered by Medicare in the calendar year for the actual charges up to 100 percent of the Medicare-approved amount for each service (as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology Codes), subject to a maximum benefit of \$120.00 per calendar year:

i. An annual clinical preventive medical history and physical examination that shall include patient education to address preventive health care measures and preventive screening tests and/or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

12. "Skilled Nursing Facility Care" means coverage for the actual billed charges up to the Medicare coinsurance amount from the 21st day through the 100th day in a Medicare benefit period, for post-hospital skilled nursing facility care eligible under Medicare Part A.

New Rule, R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on loss ratio standards recodified to 23.11; new rule added on minimum benefit standards for policies and certificates delivered or issued for delivery on or after the effective date of this subchapter.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

In (e), inserted a new 6, recodified former 6 through 9 as 7 through 10, and added 11; and in (g)3v, inserted "(or in the case of hospital outpatient department services under a prospective payment system, the copayment amount)".

Amended by R.2003 d.220, effective May 19, 2003.

See: 35 N.J.R. 71(a), 35 N.J.R. 2184(a).

Rewrote (c); in (g), substituted "services paid under" for "services under" preceding "a prospective payment system" in 3v.

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Deleted "." from the rule heading; rewrote (c), (e), (f), and (g).

Case Notes

Under regulations adopted by Department of Banking and Insurance (DOBI), payment made by the patient's Medigap insurer to hospital utilizing the diagnostic related group (DRG) reimbursement formula established by Health Care Financing Administration was full payment of the carrier's obligation to the hospital. *Valley Hospital v. Kroll*, 847 A.2d 636.

Hospital seeking to collect balance of patient's bill representing gap between its "standard" charges and benefits paid to it by Medicare and patient's Medigap insurance could not charge patient more than Medicare rate, and thus could not balance bill patient for services he received post-Medicare, as New Jersey's regulatory scheme barred balance billing of Medigap patients, and exposing the elderly or their estates to liability for amounts that a hospital's rate exceeded the Medicare-approved rate was at odds with the goal of Medigap insurance. *Valley Hospital v. Kroll*, 847 A.2d 636.

Interpretation of New Jersey regulation as prohibiting hospital from billing patient for gap between its "standard" charges, and benefits paid to it by Medicare and patient's Medigap insurance, was not preempted

by federal law, as Medicare Act and associated regulations contained no express preemption provision, and New Jersey's regulatory scheme regulated an area within the traditional realm of state police power. *Valley Hospital v. Kroll*, 847 A.2d 636.

11:4-23.9 Open enrollment

(a) Carriers shall not deny or condition the effectiveness or issuance, nor discriminate in the pricing, of Medicare supplement policies or certificates based on the health status, claims experience, receipt of health care by, or medical condition of an applicant if the application is submitted for Medicare supplement coverage prior to or during the six month period beginning with the first day of the first month in which the applicant is 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate shall be made available to all applicants who qualify under this section without regard to age.

(b) If an applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the carrier shall not exclude benefits based on a preexisting condition.

(c) If the applicant qualifies under (a) above and submits an application during the time period referenced in (a) above and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the carrier shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in N.J.A.C. 11:4-23.12, 23.16(d) and in (b) and (c) above, nothing in (a) above shall be construed to prohibit or limit a carrier's use of permissible preexisting condition exclusion provisions in any Medicare supplement policy or certificate as set forth in this subchapter.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on filing requirements recodified to 23.12; new rule added on open enrollment.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Inserted new (b) and (c); and recodified former (b) as (d), and inserted "and in (b) and (c) above" following "N.J.A.C. 11:4-23.15(d)".

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

In (d), substituted "23.12, 23.16(d)" for "23.15(d)" following "11:4-".

11:4-23.10 Standards for claims payment

(a) Every carrier providing Medicare supplement policies and certificates shall comply with Section 1882(c)(3) of the Social Security Act as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) by:

11:4-23.15 Required disclosure provisions

(a) General rules concerning required disclosure provisions include the following:

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specification of such provision shall be consistent with the type of policy or certificate to be issued. Such provision shall appear on the first page of policies and certificates, and shall include any reservation by the carrier of a right to change premiums and any automatic renewal premium increases based on the policyholder's or certificateholder's age.

2. Except for riders or endorsements by which the carrier effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy or certificate, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits:

i. All riders or endorsements added after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage shall require signed acceptance by the insured;

ii. After the date of the policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium or subscription charges during the policy or certificate term, shall be agreed to in writing signed by the insured, except if the increased benefits or coverage are required by the minimum standards of this State for Medicare supplement coverage, or if required by other law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth clearly.

3. A Medicare supplement policy or certificate shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

4. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph in the policy or certificate and be labeled as "Preexisting Condition Limitations."

5. Medicare supplement policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the insured shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium or subscription charge or fees refunded if, after examination of the policy or certificate, the insured is not satisfied for any reason.

6. Carriers issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred, indemnity, or service benefit basis to persons eligible for Medicare shall provide to all applicants an informational brochure entitled "Guide to Health Insurance for People with Medicare," hereinafter referred to as "the Guide," in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services. The Guide is intended to improve the buyer's understanding of Medicare and ability to select the most appropriate coverage. Delivery of the Guide shall be made whether or not policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as set forth by this subchapter.

7. To ensure uniformity in content, form and printing, the Guide has been made available through the Publications Department of the National Association of Insurance Commissioners, Kansas City, MO.

8. Except in the case of direct response carriers, delivery of the Guide shall be made to the applicant at the time of application, and acknowledgment of receipt of the Guide shall be obtained by the carrier. Direct response carriers shall deliver the Guide to the applicant upon request but in no instance shall delivery of the Guide occur later than the time of policy or certificate delivery.

9. Except as provided in (c) below, the terms "Medicare Supplement," "Medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with N.J.S.A. 11:4-23.8 and all other sections of this subchapter.

(b) Outline of Coverage requirements for Medicare supplement policies and certificates shall include:

1. Carriers issuing Medicare supplement policies or certificates for delivery in this State shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant. Except for direct response policies or certificates, acknowledgment of receipt of such outline shall be obtained by the carrier from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare Supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate actually issued must accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

3. The outline of coverage provided to applicants pursuant to (b)1 above shall be in the language and format

prescribed in Exhibit D of the Appendix of this chapter, incorporated herein by reference, in no less than 12 point type. The outline of coverage shall consist of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the carrier. All plans A through L shall be shown on the cover page, and the plan(s) offered by the carrier shall be prominently identified. Premium information for the plan(s) offered by the carrier shall be provided on the cover page, or immediately following the coverage page, clearly and prominently, specifying both the premium and the mode. All possible premiums for the applicant on all plans offered to the applicant by the carrier shall be illustrated.

(c) All health and disability income policies, except as specified in this subsection, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy. Such notice is not required for: Medicare supplement policies; policies of one or more employers or labor organizations, of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or members or former members, or combination thereof, of the labor organization; or policies issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. §§ 1395 et seq.). The notice shall either be printed or attached to the first page of the outline of coverage delivered to the insureds under the policy, or, if no outline of coverage is delivered, to the first page of the certificate or policy delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

“THIS IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.”

1. Applications provided to persons eligible for Medicare for the health insurance policies described above shall disclose, using the applicable statement in Exhibit H in the Appendix the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with the application for the policy or certificate.

(d) At least 30 days prior to the effective dates of any Medicare benefit changes, notice shall be provided by carriers to New Jersey insureds describing the revisions of the Medicare program and the resulting modifications made by the carrier to an insured's Medicare supplement policy or certificate to eliminate duplication of Medicare benefits.

1. The notices shall be in the format set forth in the Appendix to subchapters 16 and 23 of this chapter, Exhibit C (Notice of Changes in Medicare and Your Medicare Supplement Coverage), which is incorporated herein as part of this rule.

2. No modification shall be made to an existing Medicare supplement policy or certificate when notices are sent except those modifications necessary to eliminate duplication of Medicare benefits.

3. Notices shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

4. Notices shall provide information as to when any premium adjustment is to be made due to changes in Medicare.

5. Information on benefit modifications and premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

6. Notices shall not contain or be accompanied by any solicitation.

7. No notice shall contain benefits and premium information for more than one policy or certificate form.

(e) Carriers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

Amended by R.1987 d.95, effective February 2, 1987.

See: 18 N.J.R. 2103(a), 19 N.J.R. 291(a).

(a)6 substantially amended; (a)7 old text deleted and new text substituted.

Amended by R.1988 d.587, effective December 19, 1988 (operative January 1, 1989).

See: 20 N.J.R. 2510(a), 20 N.J.R. 3155(c).

Substantially amended.

Amended by R.1991 d.121, effective March 4, 1991.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(c).

In (a)6 and 7iii: revised internal references; deleted (a)7iv, which was outdated text. In (a)7ii(3)-(4): revised required paper to be used.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.8.

Deleted “or nonrenewal”, “clearly state the duration, where limited, or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed. Such provision shall”, “individual” in (a)1. Added (a)2.

Recodified existing (a)2 through 9 as 3 through 10.

Deleted “or hospital or medical service corporation.”, “or subscriber”, “all” in (a)3.

Designated 3i and ii; deleted “or subscriber”.

Added “are required by the minimum standards for Medicare supplement insurance policies, or if” in (a)3ii.

Stylistic changes in (a)4, 5.

Deleted “, other than those issued pursuant to direct response solicitation.”, “policyholder or certificate holder”, “person or subscriber”, “Medicare Supplement policies or certificates”; added “insured”, “or fees”; changed “10” days to “30” days in (a)6.

Deleted “and hospital and medical service corporations”, “or subscriber contracts”; added “Delivery of the informational brochure shall be made whether or not policies are advertised, solicited or issued as Medicare supplement policies as set forth by this subchapter.” in (a)7.

Changed “format” to “form” in (a)8.

Deleted “or service corporations” in (a)9. Added “and all other sections of this subchapter” in (a)10.

Deleted “or service organizations”; added “or certificates” in (b)1.

Added 5v. in Outline; deleted “N.J.A.C. 11:4-23.8(5)”; added “section 4” in 6 (outline).

Deleted "Any group", "insurance policy or individual or group subscriber contract", "subscriber contract"; added "All", "and disability income policies", "policy" in (c).

Added (d).

Substantial changes in format of the (b)3 outline as follows: Added "And Premium Information" to heading; added "Use this outline to compare benefits and premiums among policies"; added "and indexed copayments or deductibles, as appropriate" in (b)3 outline 4.

Changed "Service" to "Description"; deleted "Benefit" and "Medicare Pays" columns.

Added "I. Minimum Standards ..."; deleted "Hospitalization" and "Post-Hospital Skilled Nursing Care".

Added "II. Additional Benefits ...".

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on requirements for marketing recodified to 23.17; rule on required disclosure provisions recodified from 23.11; Outline of Coverage deleted; individualized Medicare supplement plan charts added; new disclosures required.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Substantially amended (a)6 and 7.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Recodified from N.J.A.C. 11:4-23.14 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.15, Requirements for application forms and replacement coverage, recodified to N.J.A.C. 11:4-23.16.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

Amended by R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

In (a), substituted "Centers for Medicare and Medicaid Services" for "Health Care Financing Administration" in 6; in (b)3, deleted "to subchapters 16 and 23" following "Appendix" and substituted "L" for "J" following "A through"; added (e).

11:4-23.16 Requirements for application forms and replacement coverage

(a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has a Medicare supplement or Medicare Advantage, Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policies or certificates in force. A supplementary application or other form to be signed by the applicant and agent may be used. The application form or supplementary application form shall contain the questions and statements set forth below.

1. Statements shall be as follows:

i. You do not need more than one Medicare supplement policy.

ii. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

iii. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

iv. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under

your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you were enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

v. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based health plan. If the Medicare supplement policy provided for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will be substantially equivalent to your coverage before the date of suspension.

vi. Counseling services may be available in your State to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the State Medicaid program including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

2. If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

3. Questions, which shall be numbered 1, 2, 3, 4 and 5, shall be as follows and shall be prefaced by the statement "To the best of your knowledge" and, unless noted differently, should be answered yes or no:

i. (1) Did you turn 65 in the last 6 months?

(A) Yes _____ No _____

(2) Did you enroll in Medicare Part B in the last 6 months?

(A) Yes _____ No _____

(3) If yes, what is the effective date?

(A) _____

ii. Are you covered for medical assistance through the State Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of Cost," please answer NO to this question.)

(1) Yes _____ No _____ If yes

(A) Will Medicaid pay your premiums for this Medicare supplement policy?

(B) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

iii. (1) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

(A) START ___/___/___ END ___/___/___

(2) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

(A) Yes _____ No _____

(3) Was this your first time in this type of Medicare plan?

(A) Yes _____ No _____

(4) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

(A) Yes _____ No _____

iv. (1) Do you have another Medicare supplement policy in force?

(A) Yes _____ No _____

(2) If so, with what company, and what plan do you have (optional for Direct Mailers)?

(A) _____

(3) If so, do you intend to replace your current Medicare supplement policy with this policy?

(A) Yes _____ No _____

v. (1) Have you had coverage under any other health insurance plan within the last 63 days?

(A) Yes _____ No _____

(2) If so, with what company and what kind of policy?

(A) _____

(3) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

(A) START ___/___/___ END ___/___/___

(b) Agents shall list any other health policies which they have sold to the applicant that are currently in force, and any such policies sold to the applicant within the previous five years that are no longer in force, clearly indicating which policies are in force and which are not.

(c) Upon determination that a sale will involve replacement of Medicare supplement coverage, a carrier or its agent shall furnish to the applicant, prior to the issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and agent, except where coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the carrier. A direct response carrier shall deliver to the applicant at the time of the issuance of the policy (certificate) the notice regarding replacement of Medicare supplement coverage.

(d) Carriers shall include a waiver of all preexisting condition exclusion clauses, waiting periods, elimination periods or probationary periods in a replacement policy for at least that same period of duration of the conditional clause(s) in the applicant's existing policy which has expired at the time of issuance of the replacement policy, to the extent of the benefits of the existing policy.

(e) The notice required by (c) above shall be provided in substantially the form set forth in Exhibit E of the Appendix to Subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 12 point type. Item (1) of the notice set forth in Exhibit E may be omitted or modified if preexisting conditions are covered under the new coverage. If the policy or certificate is guaranteed issue, item (3) of the notice of Exhibit E may be omitted.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section 23.9 "Requirements for replacement" recodified and reworded— "Requirements for application forms and replacement coverage".

Added "or certificate", "or Medicare supplement", "or is intended to be additional to any such policies or certificates", "and agent, except where coverage is not sold through an agent," "the questions shall be substantially as follows:" in (a). Added (a)1 through 4. Added (b), (d). Recodified existing (b) and (c) and (e) as (c), (e) and (f).

Recodified from N.J.A.C. 11:4-23.21 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Former N.J.A.C. 11:4-23.22, Severability, recodified to N.J.A.C. 11:4-23.23.

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

11:4-23.23 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is held to be invalid for any reason, the remainder of the subchapter and the

application of such provision to other persons or circumstances shall not be affected thereby.

Amended by R.1991 d.345, effective July 1, 1991.

See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a).

Section recodified from 23.10.

Changed "rule" to "subchapter" with stylistic changes.

Recodified by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

Rule on severability recodified from 23.17, without change.

Recodified from N.J.A.C. 11:4-23.22 by R.1999 d.38, effective December 28, 1998 (to expire February 26, 1999).

See: 31 N.J.R. 181(a).

Adopted concurrent proposal, R.1999 d.100, effective February 26, 1999.

See: 31 N.J.R. 181(a), 31 N.J.R. 876(a).

**PLAN L
MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR**

Once you have been billed \$[***] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[***] of Medicare Approved Amounts****	\$0	\$0	\$[***] (Part B deductible)**** ◆
Preventive Benefits for Medicare Covered Services	Generally 75% or more of Medicare approved amounts	Remainder of Medicare approved amounts	All costs above Medicare approved amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ◆
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs (and they do not count toward annual out-of-pocket limit of \$[***])*
BLOOD First 3 pints	\$0	75%	25% ◆
Next \$[**] of Medicare Approved Amounts***	\$0	\$0	\$[***] (Part B deductible) ◆
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ◆
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to \$[***] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies	100%	\$0	\$0
—Durable medical equipment			
First \$[100] of Medicare Approved Amounts****	\$0	\$0	\$[***] (Part B deductible) ◆
Remainder of Medicare Approved Amounts	80%	15%	5% ◆

**** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

*** Deductible amounts and out-of-pocket limits announced annually by CMS

EXHIBIT E
NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]
- Other. (please specify)

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probational periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

* Signature not required for direct response sales.

for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

This policy must pay benefits without regard to other health insurance benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]*
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

- √ Check the coverage in **all** health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].*

* **Drafting Note:** Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

Amended by R.1991 d.121, effective March 4, 1992.

See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).

Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete.

Amended by R.1993 d.26, effective January 4, 1993.

See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

APPENDIX substantially revised.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Exhibits A and B, repealed.

Amended by R.1996 d.295, effective July 1, 1996.

See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

Amended by R.1999 d.161, effective May 17, 1999.

See: 31 N.J.R. 713(a), 31 N.J.R. 1336(a).

Repeal and New Rule, R.2005 d.291, effective September 6, 2005.

See: 37 N.J.R. 1428(a), 37 N.J.R. 3376(a).

Administrative correction.

See: 37 N.J.R. 3835(a).