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MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: JUNE 20, 1994
See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT JULY 18, 1994

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Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **September 14, 1994.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

On occasion, a proposing agency may extend the 30-day comment period to accommodate public hearings or to elicit greater public response to a proposed new rule or amendment. An extended comment deadline will be noted in the heading of a proposal or appear in a subsequent notice in the Register.

At the close of the period for comments, the proposing agency may thereafter adopt a proposal, without change, or with changes not in violation of the rulemaking procedures at N.J.A.C. 1:30-4.3. The adoption becomes effective upon publication in the Register of a notice of adoption, unless otherwise indicated in the adoption notice. Promulgation in the New Jersey Register establishes a new or amended rule as an official part of the New Jersey Administrative Code.

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NEW JERSEY REGISTER

The official publication containing notices of proposed rules and rules adopted by State agencies pursuant to the New Jersey Constitution, Art. V, Sec. IV, Para. 6 and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. Issued monthly since September 1969, and twice-monthly since November 1981.

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EXECUTIVE ORDER

(a)

OFFICE OF THE GOVERNOR
Governor Christine Todd Whitman
Executive Order No. 21(1994)
Governor's Employee Relations Policy Council

Issued: July 14, 1994.
Effective: July 14, 1994.
Expiration: Indefinite.

WHEREAS, promoting harmonious relations between the State and its employees while insuring the efficient and continuous delivery of public services is a goal of this Administration; and

WHEREAS, collective negotiations between the State and its employees concerning the terms and conditions of employment can be improved by implementing a coordinated and integrated approach to human resource management; and

WHEREAS, Executive Order No. 3, issued on April 2, 1970, created the Governor's Employee Relations Policy Council to review and evaluate the policy of the State with respect to employee relations and recommend alternatives to facilitate cooperation between the State and its employees; and

WHEREAS, Executive Order No. 4, issued on April 2, 1970, created the Office of Employee Relations in, but not of, the Department of Treasury to assist the Governor's Employee Relations Policy Council and conduct collective negotiations with employee organizations; and

WHEREAS, it is necessary to rescind Executive Orders No. 3 and No. 4 in order to reorganize these functions to maximize efficiency, service and cost-effectiveness;

NOW, THEREFORE, I, CHRISTINE TODD WHITMAN, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and statutes of the State of New Jersey, do hereby ORDER and DIRECT:

1. Executive Order No. 3(1970) is rescinded.

2. (a) There is hereby reconstituted the Governor's Employee Relations Policy Council.

(b) The Council shall consist of the Commissioner of the Department of Personnel as chairperson, the Commissioner of the Department of Labor, the Attorney General, the Chief Counsel to the Governor and the State Treasurer, or their designees. The members of the Council shall serve ex officio.

(c) The Council shall advise the Governor on employee relations policy, negotiation issues and strategies, contract acceptance, and related matters involving State employees. The Council shall serve, through counsel, as the Governor's agent in conducting collective negotiations with employee organizations.

(d) The Council shall meet at the request of the Governor or Chairperson. The Council shall render such reports to the Governor as the Council determines necessary or as the Governor directs.

3. The Council is authorized to hire such outside consultants as deemed necessary to fulfill its mandate pursuant to this Order.

4. (a) The Council is authorized to call upon any department, office, division or agency of the State to supply such statistical data, program reports, and other information or personnel and materials as it deems necessary to discharge its responsibilities under this Order.

(b) Each department, office, division or agency of the State is authorized and directed, to the extent not inconsistent with law, to cooperate with the Council and to furnish it such information and assistance as it may find necessary in the discharge of its responsibilities under this Order.

5. Pursuant to N.J.S.A. 52:17A-4 and 11, attorneys assigned by the Attorney General shall appear as the Council's representative before the New Jersey Public Employment Relations Commission and any other board, commission, court or agency in matters involving employee relations.

6. Executive Order No. 4(1970) is rescinded.

7. There is hereby reconstituted the Office of Employee Relations within the Department of Personnel which shall be headed by an Assistant Commissioner for Employee Relations. The Assistant Commissioner for Employee Relations shall be appointed by the Commissioner of Personnel and shall serve at the pleasure of the Commissioner. The Assistant Commissioner for Employee Relations shall oversee the operations of the Office of Employee Relations.

8. The responsibilities of the Office of Employee Relations shall include, but not be limited to:

(a) administration and policy interpretation of labor agreements;

(b) coordinating data collection, information dissemination, reporting, liaison and training activities with other departments;

(c) providing support staff to the Governor's Employee Relations Policy Council; and

(d) offering recommendations to the Governor's Employee Relations Policy Council concerning employee relations and related matters involving State employees, and rendering such reports to the Council as the Council may direct or the Assistant Commissioner for Employee Relations determines.

9. In addition thereto, the Commissioner of Personnel may transfer any and all functions currently performed within the Department of Personnel to the Office of Employee Relations as the Commissioner deems appropriate.

10. (a) All appropriations, personnel, records and property associated with the Office of Employee Relations shall be reallocated within the Department of Personnel in such a manner as the Commissioner of Personnel deems appropriate in order to maximize efficiency, service and cost-effectiveness.

(b) The treatment of current personnel in the Office of Employee Relations shall be consistent with the standards set forth in P.L. 1971, c.375 (C.52:14D-1 et seq.), the "State Agency Transfer Act."

(c) Except as herein otherwise provided and in accordance with Title 11A, Civil Service, of the New Jersey Statutes, allocation of the Office of Employee Relations to the Department of Personnel shall not alter or change the term, tenure of office, rights, obligations, duties or responsibilities otherwise provided for the Office.

11. (a) The Office of Employee Relations is authorized to call upon any department, office, division or agency of the State to supply such statistical data, program reports, and other information or personnel and materials as it deems necessary to discharge its responsibilities under this Order.

(b) Each department, office, division or agency of the State is authorized and directed, to the extent not inconsistent with law, to cooperate with the Office and to furnish it such information and assistance as it may find necessary in the discharge of its responsibilities under this Order.

12. This Order shall take effect immediately.

RULE PROPOSALS

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Mortgage Commitments; Mortgage Bankers; Advertising

Proposed Amendments: N.J.A.C. 3:1-16.2 and 16.5; 3:2-1.4; and 3:38-1.3, 1.6, 1.9 and 5.1

Authorized By: Elizabeth Randall, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:1-8.1, 17:11B-13, 17:16F-13 and 17:16H-3.

Proposal Number: PRN 1994-449.

Submit comments by September 14, 1994 to:

Rule Comments
Attn: Elaine Ballai, Regulatory Officer
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

Summary

The Department of Banking proposes to amend its mortgage processing regulations in response to a practice which is becoming more common in the mortgage lending industry. In particular, a lender commits to make a mortgage loan but does not close the loan in its own name. Rather, the lender assigns the commitment thereby permitting another lender to close the loan.

The Department of Banking proposes an amendment at N.J.A.C. 3:1-16.5(e) to permit this practice, so long as the ultimate lender is authorized to make mortgage loans in this State. Further, the lender who committed to make the mortgage loan must obtain and maintain for five years a copy of the mortgage note and closing statement, along with all other required records. In this way, the Department may monitor compliance.

The proposed amendment provides that the lender who committed to make the mortgage loan remains responsible for ensuring that the ultimate lender closes the loan in accordance with the terms and conditions of the commitment and applicable New Jersey and Federal laws and regulations. For example, if a lender commits to make a loan and the ultimate lender charges improper fees, the original lender who committed to make the loan may be held responsible for making refunds of those fees. Of course, the ultimate lender may also be liable.

In addition, the Department proposes an amendment at N.J.A.C. 3:1-16.2(d) to codify its current practice of requiring persons to make restitution for fees which are impermissible or improperly charged, and to make refunds when required.

The Department proposes to amend N.J.A.C. 3:2-1.4 to require that the advertisement by a mortgage banker or mortgage broker which does not include the name, address and telephone number of the licensee is a deceptive and misleading practice. Consumers responding to advertisements have the right to know with whom they are dealing, and the address of the licensee. Further, disclosure of this basic information will facilitate the Department's efforts to ensure compliance.

The Department next proposes an amendment at N.J.A.C. 3:38-5.1 to clarify that persons who originate or broker mortgage loans secured by New Jersey residential real estate from outside New Jersey must obtain a license under the Mortgage Bankers and Brokers Act, N.J.S.A. 17:11B-1 et seq. (the "Act"). The Act defines a mortgage loan as "any loan secured by a first mortgage on real property on a one to six family dwelling, a portion which may be used for nonresidential purposes" (see N.J.S.A. 17:11B-1(a)). This section does not specify whether interstate mortgage loans secured by New Jersey property are regulated by the Act. However, in other rules promulgated by the Department concerning first mortgage lending, the Department has indicated that first lien residential mortgage loans secured by New Jersey real property are regulated transactions. See N.J.A.C. 3:1-16.1 which defines "mortgage loan" as any closed-end loan secured by a first mortgage on real property located in New Jersey. The proposed amendment at N.J.A.C. 3:38-5.1 is therefore consistent with this policy.

At N.J.A.C. 3:38-1.3, the proposed amendment requires that a licensee seeking to convert from a mortgage banker to a mortgage banker non-servicing or from a mortgage banker non-servicing to a mortgage banker also submit the licenses of all its licensed individuals and a $25.00 fee for each.

The Department next proposes to change the surety bond amounts required for mortgage bankers and brokers. Currently, the required bond amount ranges from $25,000 to $125,000, depending upon the number of licensed individuals. This system has been a disincentive for banker or brokers to hire individual licensees, a result not intended by the Department. Further, the number and amount of bond claims received by the Department has increased, thereby necessitating an increase in the bond requirements. Finally, the current system requires a licensee to change the bond amount when the number of individual licensees increases or decreases. This is an added administrative cost for the licensee and the Department.

In light of these factors, the Department proposes amendments at N.J.A.C. 3:38-1.6(d) and (e) to set the bonding requirement for mortgage brokers at $50,000, and for mortgage bankers and mortgage bankers non-servicing at $150,000. The amount for mortgage brokers is less because these licensees are only permitted to take application fees prior to closing, and their exposure is therefore also much less.

The Commissioner under these proposed amendments will be authorized to increase the amount of the surety bond based on the following factors: (1) volume of applications; (2) number of complaints received by the Department against the licensee; (3) financial responsibility of the applicant or licensee, including the ability of the applicant or licensee to provide funding for loans; (4) number of branches and licensed individuals; and (5) violations of statutes or regulations disclosed in Departmental examinations.

Current rules, at N.J.A.C. 3:38-1.9(e) require a licensee who relocates a branch office more than 1,500 feet, to file a new branch office application. The Department proposes to delete this provision to allow a licensee to relocate a branch office anywhere within the State.

Social Impact

Requiring licensing of out-of-State mortgage lenders who make loans secured by New Jersey property will have a positive social impact. In particular, New Jersey residents who borrow from these lenders will be afforded the same protections as New Jersey residents who borrow from New Jersey lenders.

Increasing the surety bond will have the positive social impact of providing greater protection to borrowers. Similarly, requiring restitution for licensees who improperly take or retain fees, allows the Department to provide a suitable remedy to consumers who are victimized by the taking of improper fees.

Economic Impact

Requiring licensing of out-of-State licensees requires those persons to submit a license fee and to submit to Departmental examinations. This will have a negative economic impact on those persons and a corresponding economic benefit to the State.

In addition, the proposed amendments at N.J.A.C. 3:38-1.3(g) require a licensee converting between a mortgage banker non-servicing and a mortgage banker, to submit $25.00 for the conversion of each licensed individual. This will have a nominal negative economic impact on licensees.

The Commissioner currently has the authority to order restitution for fees taken which are impermissible or improperly charged, and to order refunds. The proposed amendment at N.J.A.C. 3:1-16.2(d) merely codifies this current practice. Accordingly, it is not expected that it will have an economic impact.

Increasing the amount of the surety bond at N.J.A.C. 3:38-1.6(d) and (e) will have a negative economic impact on the licensee, since the licensee will need to pay added premiums. However, increasing the surety bond will have a positive economic impact on borrowers who seek to file claims against the bond.

The committing lender under the proposed amendments at N.J.A.C. 3:38-5.1 remains responsible for ensuring that the ultimate lender closes the loan in accordance with terms and conditions of the commitment. This proposal will have a negative impact on lenders who are assigning loans to other lenders who are not closing the loan as agreed. In

particular, the committing lender will incur the cost of refunding these improper fees and charges. The borrower will have a corresponding positive economic impact.

Regulatory Flexibility Analysis

Most licensees under the Act are small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Compliance requirements are imposed in the form of licensing for out-of-State lenders making residential mortgage loans secured by New Jersey real estate. In addition, the Department proposes to require licensees to include their name, address and telephone number in advertisements, and to maintain records when they assign a commitment to another lender. Since these requirements are necessary to ensure compliance with the Act and Departmental regulations, no differentiation based on business size is made.

The proposed amendments also permit a licensee to move a branch office more than 1,500 feet without filing a new branch office application, which lessens compliance requirements.

The proposed amendments at N.J.A.C. 3:38-1.3(g) provide for a $25.00 fee for the conversion of each licensed individual converting between a mortgage banker and a mortgage banker non-servicing. Since this fee is intended to reimburse the Department for its administrative expenses, and these expenses exist regardless of the business size, no differentiation based on business size is made.

The increased surety bond requirement will cause the industry to incur costs for increased premiums. The Department has set $150,000 as the minimum amount of the surety bond for mortgage bankers. However, since one of the stated factors for increasing the bond amount is the volume of applications, small businesses are less likely to have such an increase.

It is not expected that these rules will require the need for additional professional services.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

3:1-16.2 Fees

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

(d) The Commissioner is authorized to order any person to make restitution for fees charged which are impermissible or improperly charged, or to make refunds when required, under these rules. Nothing in this subsection is deemed to set a limit on the amount of fees a lender may charge on a mortgage loan.

3:1-16.5 Commitment process

(a)-(d) (No change.)

(e) A lender who commits to make a mortgage loan may assign the commitment to another lender authorized to make mortgage loans in this State, or allow another such lender to close the loan, provided that:

1. The lender who committed to make the mortgage loan shall obtain and maintain for five years a copy of the mortgage note and the closing statement along with other documents required by N.J.A.C. 3:1-2; and

2. The lender who committed to make the mortgage loan shall remain responsible for ensuring that the ultimate lender closes the loan in accordance with the terms and conditions of the commitment and applicable New Jersey and Federal laws and regulations.

3:2-1.4 Violations of the Act

(a) (No change.)

(b) Without limiting (a) above, the following conduct shall be deemed deceptive or misleading:

1.-5. (No change.)

6. The advertisement of a mortgage loan or mortgage loan services by a mortgage banker or mortgage broker without including in the advertisement or broadcast announcement, **the name, address and telephone number of the licensee and** the words "licensed mortgage banker-N.J. Department of Banking", "licensed mortgage banker n.s.-N.J. Department of Banking" for a non-servicing mortgage banker or "licensed mortgage broker-N.J. Department of Banking," whichever the case may be; and

7. (No change.)

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

3:38-1.3 Applications

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

(g) A licensee shall submit the following to convert from a mortgage banker to a mortgage banker non-servicing or from a mortgage banker non-servicing to a mortgage banker;

1. The original license, [and] the licenses of all branch offices, **and the licenses of all licensed individuals**;

2.-3. (No change.)

4. A conversion fee of $200.00 plus $25.00 for each additional branch office **and for each licensed individual**.

(h)-(i) (No change.)

3:38-1.6 Bonds

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

(c) The minimum amount of the bond posted **prior to July 1, 1995** shall be:

1.-6. (No change.)

(d) For all new applicants after the effective date of this rule, and for all licensees after June 30, 1995, the minimum amount of the bond shall be:

1. For a mortgage broker: $50,000;

2. For a mortgage banker non-servicing or a mortgage banker: $150,000.

(e) The Commissioner may increase the required amount of the bond based on the following factors:

1. Volume of applications;

2. Number of complaints received by the Department against the licensee;

3. Financial responsibility of the applicant or licensee, including the ability of the applicant or licensee to provide funding for loans;

4. Number of branches and licensed individuals; and

5. Violations of statutes or regulations disclosed in Departmental examinations.

Recodify existing (d)-(i) as **(f)-(k)** (No change in text.)

3:38-1.9 Office requirements

(a)-(d) (No change.)

[(e) a licensee may relocate a branch office anywhere within 1,500 feet of an existing office or anywhere within the same building of an existing office. Relocation of a branch office more than 1,500 feet from the existing office shall require branch application.]

Recodify existing (f)-(m) as **(e)-(l)** (No change in text.)

3:38-5.1 Necessity for license

(a) No person shall act as a mortgage banker or a mortgage broker without first obtaining a license therefor, but a person licensed as a mortgage banker may act as a mortgage broker. **A person who originates or brokers mortgage loans secured by New Jersey real estate from outside New Jersey must obtain a license under the Act.** A mortgage banker non-servicing shall not service mortgage loans for more than 90 days in the regular course of business.

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

(a)

DIVISION OF REGULATORY AFFAIRS

Proposed Interstate Acquisition Determination of Eligibility

Proposed Readoption: N.J.A.C. 3:33

Authorized By: Elizabeth Randall, Commissioner, Department of Banking.

Authority: N.J.S.A. 17:12B-226 and 289.

Proposal Number: 1994-452.

Submit comments by September 14, 1994 to:

Elaine W. Ballai
Regulatory Officer
Department of Banking
CN 040
Trenton, NJ 08625

The agency proposal follows:

Summary

The Department of Banking proposes to readopt N.J.A.C. 3:33 which is scheduled to expire on September 18, 1994 pursuant to Executive Order No. 66(1978). The Department has reviewed these rules and determined them to be necessary, reasonable and proper for the purpose for which they were originally promulgated. N.J.A.C. 3:33 requires an out-of-State insured institution or out-of-State savings and loan holding company, which intends to acquire and retain control of a New Jersey insured institution or New Jersey savings and loan holding company, to file an application with the Department of Banking.

The application must contain specified information. The Commissioner shall determine whether the applicant is an eligible insured institution or eligible savings and loan holding company, and whether more than 50 percent of the deposits of the applicant's subsidiaries are in insured subsidiaries located in eligible states having reciprocal legislation in effect. The Commissioner shall also determine whether to place any limitations or restrictions on the out-of-State institution's or out-of-State savings and loan company's acquisition of the New Jersey insured institution or New Jersey savings and loan holding company. By having the Commissioner make the specified determination before issuing a certificate of eligibility, the rules help fulfill the legislative intent that the acquisition of New Jersey entities be done in a considered and orderly manner.

Social Impact

The information which is required to be submitted to the Commissioner by these rules will help the Department to make informed decisions regarding transactions to acquire New Jersey insured institutions and New Jersey savings and loan holding companies, and will assist the Department in maintaining regulatory control over the acquisition of New Jersey savings and loan associations and New Jersey savings and loan holding companies.

Economic Impact

The applicant costs involved in meeting the requirements of these rules consist of the fees required under N.J.A.C. 3:33-1.4, pursuant to N.J.S.A. 17:12B-285, and the administrative costs incurred in producing the application materials. Departmental cost for application review is at least partially offset by these fees. The public benefits through the maintenance of a sound banking system.

Regulatory Flexibility Statement

The obligation to comply with these rules falls only on out-of-State insured institutions and savings and loan holding companies. These entities are outside of the intent of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Acquisitions by in-State entities are already governed by separate provisions and are subject to the Commissioner's approval. A regulatory flexibility analysis is, therefore, not required.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 3:33.

HEALTH

(a)

EPIDEMIOLOGY

COMMUNICABLE DISEASE CONTROL SERVICE

Confinement of Persons with Tuberculosis

Proposed New Rules: N.J.A.C. 8:57-5

Authorized By: Len Fishman, Acting Commissioner, Department of Health.

Authority: N.J.S.A. 26:4-2, 26:4-60 et seq., 26:4-70 et seq. and N.J.S.A. 30:9-57.

Proposal Number: PRN 1994-468.

Submit comments by September 14, 1994 to:
Clifford G. Freund, M.P.H., Director
Communicable Disease Control Service
New Jersey Department of Health
CN 369
Trenton, NJ 08625-0369

The agency proposal follows:

Summary

The proposed new rules address the need to control the spread of tuberculosis (TB) which has now risen to epidemic levels. Of particular concern are relatively new forms of drug resistant TB which are difficult and costly to treat.

Almost all cases of TB are curable, provided that the person complies with his or her treatment plan. Incomplete and inadequate treatment not only causes the person continued illness, but also gives rise to new strains of TB that, once having been exposed to the first choice of drugs, become resistant to those drugs and thus more difficult to manage. These strains of TB are known as multiple drug resistant TB (MDR-TB). The total cost of treating one MDR-TB patient can reach $250,000 and some cases are not curable.

Unlike many other illnesses, highly effective treatments for TB are currently available. The purpose of these rules, therefore, is to maximize the utilization of these currently available and highly effective treatments, thereby controlling the spread of this dangerous, costly, and largely preventable disease.

With the advent of effective antibiotic treatment for tuberculosis, the focus of the control of this communicable disease has shifted from an inpatient institutional setting to an outpatient and community setting. In most instances, the TB patient can be treated and cured, and his or her contacts adequately tested and treated on an outpatient basis. The most important determinants in the appropriate treatment facility or setting are the medical status of the person and the willingness and/or capability of the person to comply with his or her prescribed treatment regimen.

Persons who are very ill require more intensive medical care than can be administered on an outpatient basis, and therefore are best treated initially as an inpatient with an acute care hospital. All other persons capable of functioning at an outpatient level can be treated in a less restrictive manner within the existing primary care structure. These rules are to address those components necessary for such treatment to successfully take place.

Outpatient TB care places a strong emphasis on education and communication between the medical care provider and the person to ensure that the person understands how serious tuberculosis is, what will be necessary to cure the disease, and how to prevent its spread. In addition to such education, the communication process and the overall patient-provider relationship will be strengthened through the use of a case management approach. Case managers can work with patients on a one-to-one basis to address all those factors that affect the successful completion of the TB treatment regimen. Using both patient input and documentation of results, case managers can consistently revise the treatment plan to assure the greatest degree of compliance with each person's medication plan.

It is anticipated that the need for detention will be limited to those few instances where all other treatment plans and opportunities fail. This level of care will provide the basis for adequate documentation and description of these exceptional occasions when outpatient treatment cannot be the most appropriate setting for tuberculosis treatment.

Two core principles guide these rules: (1) to protect public health from the spread of disease; and (2) to treat persons having infectious, active, or clinically suspected active TB in the least restrictive environment possible.

These principles are outlined in N.J.A.C. 8:57-5.1.

N.J.A.C. 8:57-5.2 defines the terms applicable to this subchapter.

N.J.A.C. 8:57-5.3 states which events related to tuberculosis are reportable, who is responsible for these reports, to whom and where reports are made, and in what period of time the reports shall be made. Reports of Tuberculosis are authorized under N.J.S.A. 26:4-2c. and N.J.S.A. 26:4-60. Other reporting requirements are needed to stop the spread of TB and MDR-TB and are authorized by N.J.S.A. 26:4-70 et seq.

N.J.A.C. 8:57-5.4 states that each person with active TB shall be assigned a case manager and delineates the responsibilities of the assigned case manager. This section also covers the outreach services that may be provided to persons with active and clinically suspected TB and their close contacts.

N.J.A.C. 8:57-5.5 prescribes how persons believed to have clinically suspected active TB, based on direct observation of a health care provider, shall be required to submit to a diagnostic examination. It further prescribes that close contacts of a person with infectious TB, as defined in N.J.A.C. 8:57-5.2, shall be required to submit to diagnostic

examinations. These examinations are necessary to prevent the spread of this communicable disease, pursuant to N.J.S.A. 26:4-2e, N.J.S.A. 26:4-70 and N.J.S.A. 30:9-57.

As stated earlier in this summary, the advent of antibiotic treatment of TB has shifted the focus of treatment from an inpatient institutional setting to an outpatient and community setting. However, for outpatient treatment to be effective and in order to prevent the spread of TB and the development of MDR-TB, it is necessary to carefully manage and monitor the treatment of persons with active TB. N.J.A.C. 8:57-5.6 states the requirements for clinical management of TB on an outpatient basis.

As authorized under N.J.S.A. 26:4-2e. and N.J.S.A. 26:4-70, N.J.A.C. 8:57-5.7 describes the cases in which the local health officer shall issue an order for detention in designated facilities. This section also states that persons detained under this section shall be given notice as to the reasons for detention, shall be given a hearing pursuant to N.J.A.C. 8:57-5.8 and shall be assured due process in accordance with N.J.A.C. 8:57-5.9.

N.J.A.C. 8:57-5.8 states that if any person detained pursuant to these rules requests release, such person shall be afforded the opportunity to be heard in court, in accordance with the authority contained in N.J.S.A. 30:9-57. This hearing will result from the requirement that the health officer shall make an application for a court order authorizing the detention within three business days of the detainee's request for release. The person requesting release may not be held without a court order for more than five business days after such a request. This section also states that any person detained, whether they request release or not, shall not be detained for more than 60 days without a court order and the local health officer shall see further court review within 90 days of each subsequent court order.

N.J.A.C. 8:57-5.9 states the due process rights afforded a person detained under these rules.

Pursuant to N.J.S.A. 30:9-57 and N.J.S.A. 26:4-70, N.J.A.C. 8:57-5.10 requires that the medical director of the detention facility request the local health officer or the court to terminate the order for detention prior to releasing any person detained under these rules. This request must be accompanied by a discharge plan which conforms to the requirements of this section. This section provides that a person shall be released only when there is no reasonable risk that the person will transmit TB.

N.J.A.C. 8:57-5.11 states that the Commissioner of Health shall designate sufficient detention facilities from among those facilities which submit proposals to the Department. This section also outlines the minimum requirement of these proposals and the way they will be processed by the Commissioner.

N.J.A.C. 8:57-5.12 is proposed, in order to provide guidance to local health officers and to provide a clear and consistent process for health officers to follow during the detention of a person under these rules.

N.J.A.C. 8:57-5.13 states that the Chief of the TB Control Program shall submit an annual report to the Commissioner, describing the trends in prevalence and incidence of TB and MDR-TB in New Jersey.

N.J.A.C. 8:57-5.14 describes the confidentiality associated with the records of a person subject to these rules and the circumstances under which the records may be released.

Pursuant to N.J.S.A. 26:4-2, N.J.A.C. 8:57-5.15 describes how a local health officer may order a person with known infectious TB to be excluded from attending his or her place of work or school or other premises when it is necessary to protect others from the spread of the disease. It also states the circumstances where the local health officer shall revoke the order for exclusion.

N.J.A.C. 8:57-5.16 describes the authority of a local health officer in the area where a person subject to these rules frequents. In order to preserve the health of the person in question or the public safety, this local health officer may take any action authorized by these rules, but shall notify the health officer with primary responsibility within 72 hours of the actions taken.

N.J.A.C. 8:57-5.17 provides the penalties to be assessed to any person who fails to adhere to any of the provisions of these rules, pursuant to N.J.S.A. 26:4-129 et seq.

Social Impact

The need for these rules is precipitated by an increase in the incidence of TB in the New Jersey-New York metropolitan area, attributed to social problems such as homelessness, drug addiction, alcohol abuse and non-compliant patients. The confluence of these factors is widely recognized as the main contributor giving rise to MDR-TB and the increase in TB in general. Additionally, the AIDS epidemic has exacerbated the problem because persons with AIDS are at a higher risk of becoming infected with and transmitting TB.

These rules strive to strike a delicate balance between the rights to individual liberty and the protection of the public interest through the prevention and control of TB, a devastating air-borne disease. In limited circumstances and under narrowly drawn criteria, persons may be involuntarily detained and/or subject to quarantine.

These rules will have a substantial impact on individuals and families of individuals who require detention. Although the involuntary holding provisions will be invoked infrequently, for those individuals involved the impact of these rules is significant. On the other hand, for persons who would have contracted TB or MDR-TB but for the involuntary quarantine of a non-compliant person with infectious or clinically suspected active TB, there will be a substantial beneficial effect.

Health care providers will also be affected by these rules. The rules require that physicians monitor patient appointment-keeping behavior; take various steps to enforce compliance with the prescribed treatment regimen; and contact the Department and/or local health authorities. Health care providers must also submit reports of new enrollments, terminations, loss of contact and other events to the TB Control Program in the Division of Epidemiology, Environmental and Occupational Health Services.

Economic Impact

Health care providers who treat TB patients and local health officers will have increased administrative costs resulting from the additional reporting, recordkeeping and follow-up required under the rules. The community based outpatient treatment system, which includes case management staff and health care workers, will require funding. Also, there will be administrative costs to the State court system resulting from hearings on long term institutionalization, involuntary detention for TB examinations and review of petitions for release from involuntary institutionalization. Cost of institutional care will also result where such charges are not otherwise reimbursable.

To the extent that more persons with active or clinically suspected active TB seek, or are ordered to seek, treatment, there may also be an increase in testing and laboratory costs affecting patients, their insurers and subsidy programs for the uninsured resulting from mandatory TB examinations and incidental costs of increased patient monitoring.

On the other hand, the substantial cost of MDR-TB treatment (estimated at $250,000 per case) will be avoided and the total cost of drug sensitive TB treatment will be reduced. Because TB disease disproportionately affects the uninsured and underinsured, State and Federal programs that would otherwise pay for this treatment would be the most significant beneficiaries of these savings.

The rules should not cause any new facility construction. Existing structures should be sufficient to handle the low volume of quarantined persons. Moreover, because the purpose of quarantine is isolation and compliance, the detained person will generally not require expensive medical technologies. Instead, existing structures will likely undergo modifications to enable them to house persons requiring either short term or long term detention. The cost of facility modification required to provide adequate custodial care for patients and to sufficiently protect others from transmission of the disease will affect those entities who request participation in the program.

Regulatory Flexibility Analysis

These rules may affect solo private practitioners or group practices, both of which may be considered a "small business" under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These health care providers are required to maintain appointment keeping records, report certain events to authorities, order diagnostic examinations and schedule follow-up appointments. Most of these tasks are normally conducted and thus do not constitute an additional burden. Tasks which are not normally performed include the reporting of certain events to health officers or the Department of Health. These events include refusals to submit to a TB examination, enrollment and termination from outpatient treatment protocols, loss of contact with a TB patient, and medical discharge from involuntary institutionalization. It is not anticipated that these additional administrative tasks will be particularly burdensome and many reportable events will be rare occurrences (for example, refusal to submit to TB examination or medical discharge from involuntary hospitalization). In view of the essential nature of the information to TB control, the additional administrative burden created by the need for such data is unavoidable.

It is also possible that facilities responding to the Department's request for proposals for detention sites may be within the scope of the Regulatory Flexibility Act; however, the rules make no administrative or other demands on those entities, and may be completely avoided if the facility decides not to submit a proposal. Arrangements between the Department of Health and providers of involuntary detention places will be in accordance with the request for proposals (RFP) process provided for in the rules, at N.J.A.C. 8:57-5.11. The programs electing to participate in the RFP process will incur minimal administrative and processing costs in the course of the application process. No professional services, such as legal, engineering, or accounting services, are required by these rules.

Because of the need to assure that designated facilities will meet the minimum standards for diagnosis, treatment, and security of the persons confined to the facilities, in order to protect both the public health and welfare and the rights of any individuals confined or treated in accordance with this subchapter, it is not possible to provide differential treatment in these rules for any applicants or other regulated entities which may be small businesses.

Full text of the proposed new rules follows:

SUBCHAPTER 5. CONFINEMENT OF PERSONS WITH TUBERCULOSIS

8:57-5.1 Purpose and scope

(a) The purpose of these rules is to control the spread of tuberculosis, particularly new forms of multiple drug resistant TB (MDR-TB) by maximizing the use of currently available and highly effective treatments.

(b) Local health officers are primarily responsible for implementation of these rules. Physicians and other providers of health care services, including, but not limited to, hospital administrators and emergency medical technicians, also have responsibilities under these rules. These rules apply to persons who have active TB disease or who are suspected by a health care provider or local health officer of having active TB disease.

(c) Two core principles shall be followed in the implementation of these rules:

1. To protect the public from the spread of active TB disease; and

2. To treat persons with active TB or suspected TB in the least restrictive environment.

8:57-5.2 Definitions

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

"Active TB" means that:

1. A person has a sputum smear or culture taken from a pulmonary or laryngeal source and has tested positive for tuberculosis and the person has not completed an appropriate course of medication for tuberculosis;

2. A smear or culture taken from an extra-pulmonary source on a person has tested positive for tuberculosis and there is clinical evidence or clinical suspicion of pulmonary tuberculosis disease and the person has not completed an appropriate prescribed course of medication for tuberculosis; or

3. In those cases where sputum smears or cultures are unobtainable, the radiographic evidence, in addition to current clinical evidence and/or laboratory tests, is sufficient to establish a medical diagnosis of pulmonary tuberculosis for which treatment is indicated.

"Chief of TB Control" means the Chief of TB Control in the Division of Epidemiology, Environmental and Occupational Health Services, New Jersey Department of Health, or his or her designee.

"Clinically suspected active TB" means a condition in which the person presents a substantial likelihood, as determined by a health care provider, of having active tuberculosis that is infectious, based upon epidemiologic evidence, clinical evidence, x-ray readings, or laboratory test results.

"Close contact" means a person who can be identified by a health care provider or designee or by an agency of the Department of Health, who shares common living, recreational, working, transportation or other areas with a person with infectious TB such that the frequency and/or proximity of those contacts may cause transmission of TB between the two persons.

"Compliance" means that a person takes 80 percent or more of his or her prescribed TB medication. (The term "compliance" is equivalent to the term "adherence," a term often used by the Centers for Disease Control and Prevention.)

"Commissioner" means the Commissioner of the Department of Health, or his or her designee.

"Designated detention facility or unit" means a health care facility selected by the Commissioner of Health that has submitted a proposal to provide one or more of the following when involuntary detention or quarantine is required under these rules: space for involuntary detention; space and clinical program for involuntary examination; and/or space and clinical program for quarantine and facilities for hearings under this subchapter.

"Directly observed therapy" (DOT) means a methodology for ensuring compliance with medication directions in which a health care provider or designee witnesses the person take his or her prescribed medications.

"Health care provider" means a person who is a direct provider of health care service in that the person's primary activity is the provision of health care services to individuals and, when required by State law, the individual has received professional training in the provision of such services and is licensed or certified for such provision.

"Infectious TB" means the stage of tuberculosis where mycobacterial organisms are capable of being expelled into the air by a person, as determined by laboratory, radiologic, epidemiologic or clinical findings.

"Least restrictive alternatives" means the intervention that limits the person the least, balanced against the risk to the public and individual persons based on the likelihood that TB infection would be spread.

"Local health officer" means a holder of a license as a health officer issued by the State Department of Health in accordance with applicable laws, or his or her duly authorized representative. Unless otherwise indicated, the local health officer who has primary responsibility under these rules is the local health officer of the jurisdiction in which the patient resides.

"Loss of contact" means that two documented attempts on different days and at different times, by a health care provider or designee or by an agent of the Department of Health or local health officer, to conduct a face to face meeting with a person fail because the individual was not at his or her last known residence or designated location. In the case of persons with no current address, last known residence refers to a discrete geographic area in a community in which the person was last seen with some degree of regularity.

"MDR-TB" means multiple drug resistant TB; a form of TB that is resistant to at last isoniazid and rifampin as included in the Joint Statement of the American Thoracic Society and the Centers for Disease Control and Prevention: "Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children", March 1993, as amended and supplemented.

"Medical director" means the physician with clinical responsibility for a designated detention facility.

"Social resources" means services which allow the person to successfully complete the prescribed course of treatment, including, but not limited to, food, housing, transportation, and communication.

8:57-5.3 Reportable events

(a) Every health care provider attending any person diagnosed with active tuberculosis disease shall, within 24 hours, report by phone or FAX, and in writing within 72 hours, the following events to the appropriate local health officer(s) and the Chief, TB Control Program, Division of Epidemiology, Environmental and Occupational Health Services, CN 369, 3635 Quakerbridge Road, Trenton, NJ 08625-0369, phone (609) 588-7522, FAX (609) 588-7431:

1. Persons who are newly diagnosed with active tuberculosis disease;

2. Persons who are clinically suspected of having TB who refuse or fail to submit to a TB diagnostic examination;

3. Loss of contact with any person with active TB; and

4. The name, telephone number, and address of the case manager assigned to each person with active TB in accordance with N.J.A.C. 8:57-5.4.

(b) Every health care provider attending any person diagnosed with active tuberculosis disease shall report in writing, within 72 hours, the following events to the appropriate local health officer(s) and the Chief, TB Control Program, Division of Epidemiology, Environmental and Occupational Health Services, CN 369, 3635 Quakerbridge Road, Trenton, NJ 08625-0369, FAX (609) 588-7431:

1. New enrollments in a prescribed treatment regimen in accordance with N.J.A.C. 8:57-5.6;

2. Terminations from a prescribed treatment protocol in accordance with N.J.A.C. 8:57-5.6; and

3. Medical or court ordered discharges from detention in accordance with N.J.A.C. 8:57-5.10.

(c) The local health officer shall report in writing, within 72 hours, the following events to the Chief, TB Control Program, Division of Epidemiology, Environmental and Occupational Health Services, CN 369, 3635 Quakerbridge Road, Trenton, NJ 08625-0369:

1. A person missing an appointment ordered by the local health officer in accordance with N.J.A.C. 8:57-5.5;

2. Detention to prevent loss of contact pending court order in accordance with N.J.A.C. 8:57-5.7; and

3. Orders issued by the local health officer to detain a person for TB diagnosis or treatment.

(d) Reports of events listed in (a) through (c) above shall include, but are not limited to, the person's name, address or last known location; phone number; date and specific circumstances of the reported event; and health care provider's name, address and phone number.

(e) A person who has knowledge or reasonable cause to believe that a person has TB disease shall not be subject to civil, administrative, disciplinary or criminal liability for reporting in good faith an event pursuant to these rules.

8:57-5.4 Case management and outreach services

(a) The health care provider shall assign a case manager to each person with active TB. The case manager may be the health care provider or his or her designee. The Chief of the TB Control Program shall approve the case manager for each person with active TB who receives services in a public health clinic. The case manager shall have the overall responsibility for monitoring and coordinating the implementation of the person's treatment plan. The case manager shall also assist the person to obtain services from appropriate social service agencies.

(b) The case manager shall provide educational services to persons with active TB. Educational services shall include, but are not limited to:

1. How TB is transmitted;

2. How to prevent the spread of TB;

3. How to take medications;

4. The effects of TB if not adequately treated;

5. The importance of completing the prescribed course of treatment;

6. The person's responsibility in curing his or her disease;

7. Legal consequence of noncompliance with the treatment protocol and infection control; and

8. Causes and consequences of MDR-TB.

(c) The Chief of the TB Control Program, Division of Epidemiology, Environmental and Occupational Health Services, shall direct the provision of necessary outreach services. Outreach services may include, but not be limited to, interviewing and educating persons with active and clinically suspected active TB, and their close contacts. The local health officer shall provide assistance in outreach activities, as requested by the Chief, TB Control Program.

(d) If, in the judgement of his or her health care provider, a person with clinically suspected active TB or active TB is incapable of understanding in English any communication required by these rules, the health care provider, or, at his or her direction, the case manager, shall notify the local health officer who shall arrange for such communication in a language understood by the person. If, within three days of receipt of such notice, the local health officer documents that an appropriate translation is not available at the local level, he or she shall notify the Chief of the TB Control Program who shall arrange for such translation. The determination of the Chief of the TB Control Program as to the appropriate communication shall be final. This provision shall apply only to communications required by these rules and shall not apply to any other communication arising in the context of the person's treatment.

8:57-5.5 Diagnostic examinations

(a) Where a health care provider, based on direct observation, believes that a person has clinically suspected active TB, the health care provider shall schedule an appointment for a diagnostic examination to be conducted within five business days of such observation.

(b) Persons with clinically suspected active TB shall be informed in writing by their health care provider that:

1. A diagnostic examination is required by law for persons with clinically suspected active TB;

2. Repeated failure to keep appointments for such an examination shall result in involuntary detention for the purpose of conducting the examination; and

3. Transportation assistance to the examination may be available from the local health officer.

(c) Persons with clinically suspected active TB who do not keep their appointment shall be reported to the local health officer who shall contact the person to schedule another appointment. Contacts and attempts to contact shall be documented by the local health officer. An attempt to contact is defined as going to the person's residence or other area which he or she is known to frequent. Attempts should be made on different days or at different times to maximize the opportunity to have face-to-face contact.

(d) Where a health care provider has knowledge that a person has infectious TB, the health care provider shall notify the local health officer within 24 hours of the positive report. The local health officer shall determine whether there are any close contacts that must be examined for TB.

1. If a close contact is identified who currently resides within the health officer's jurisdiction, the local health officer shall schedule the examination within 10 business days of the local health officer's notification.

2. If a close contact resides outside the local health officer's jurisdiction, the local health officer shall notify the Chief, TB Control Program, Division of Epidemiology, Environmental and Occupational Health Services, CN 369, 3635 Quakerbridge Road, Trenton, NJ 08625, FAX (609) 588-7431. Such notification shall be made in writing within three days of the local health officer's knowledge of the close contact.

i. If the close contact resides in New Jersey, the Chief, TB Control Program, shall notify the appropriate local health official who shall be responsible for scheduling the appropriate appointments.

ii. If the close contact resides outside of New Jersey, the Chief, TB Control Program, shall notify the appropriate state authorities.

iii. The residence of the close contact is defined as the contact's address, last known whereabouts or a discrete geographic area in a community in which the person was last seen with some degree of regularity.

(e) The appropriate local health officer shall schedule a diagnostic examination for TB for each close contact. The local health officer shall notify the contact of the time, place, purpose, and mandatory nature of the exam. Notification shall be made in all cases by mail, and by telephone whenever possible.

(f) If the contact does not keep the scheduled appointment, the local health officer shall reschedule the examination within 72 hours of the missed appointment. Notification of the rescheduled appointment shall be made in all cases by certified mail, return receipt requested, and by telephone or face-to-face contact whenever possible.

(g) If the contact does not keep the rescheduled appointment, the local health officer shall make and document at least two attempts to establish a face-to-face contact. Attempts are defined as going to the person's primary residence or last known whereabouts to establish a face-to-face contact. Attempts should be made on different days and at different times to maximize the opportunity to obtain a face-to-face contact.

(h) A contact who has either specifically communicated refusal to submit to a diagnostic examination, or who has missed two scheduled appointments for a diagnostic examination and who has not had a face-to-face contact with the local health officer after two attempts, shall be detained in a detention facility or unit for a diagnostic examination by order of the local health officer. The contact shall be advised of his or her rights under N.J.A.C. 8:57-5.9 before or concurrently with detention.

(i) A person who is detained solely for the purpose of a diagnostic examination shall not continue to be detained beyond the reasonable period of time, with the exercise of all due diligence required, to make a medical determination of whether the person has active or infectious tuberculosis.

(j) A diagnostic examination for a person with active, infectious or clinically suspected active TB shall consist of at least an appropriate physical examination, a chest x-ray and a mycobacterial test. A diagnostic examination for a close contact shall consist of a Mantoux tuberculin skin test and, if medically appropriate, a chest x-ray.

8:57-5.6 Clinical management of TB; outpatient basis

(a) Where a person is diagnosed with active TB, the health care provider shall immediately develop and implement a prescribed outpatient treatment plan. The person's case manager shall have the overall responsibility for monitoring and coordinating the implementation of the person's treatment plan.

(b) Each plan shall begin with 10 doses of medication under Directly Observed Therapy (DOT). After 10 doses of medication have been observed, the health care provider shall evaluate the person to determine whether the person is able and willing to follow an unobserved outpatient treatment plan or should continue on DOT. The health care provider shall monitor the medication of a person or unobserved therapy at least weekly.

(c) If a person is unable or unwilling to follow an unobserved prescribed outpatient treatment plan, the health care provider shall request the local health officer to order DOT. Indications of the need for DOT include, but are not limited to:

1. Reasonable belief that the person is not complying with the prescribed treatment plan; or

2. An appointment keeping rate under 80 percent. The appointment keeping rate is the number of kept appointments divided by the number of scheduled appointments.

(d) DOT patients shall be informed by their case manager and health care providers that DOT services will be available at a prescribed time and place. DOT patients shall be informed that they may request a reasonable change in the time and place of their DOT. Changes in time and place shall be made by the case manager, based on the patient's needs and the availability of resources.

(e) A health care provider shall recommend to the local health officer that the order for DOT be revoked if the health provider determines that the person no longer has active TB or the person is able and willing to comply with the prescribed treatment regimen without DOT. The local health officer shall base the decision to revoke DOT on the health care provider's recommendation, the patient's record, and, if deemed necessary by the local health officer, independent review by another health care provider.

8:57-5.7 Grounds for detention

(a) A local health officer shall issue an order for detention in a designated detention facility or unit in the following cases:

1. A person with clinically suspected active TB who has clearly expressed refusal to comply, or who has failed to comply, with the diagnostic examination requirements of N.J.A.C. 8:57-5.5;

2. A close contact of a person with active TB who has clearly expressed refusal to comply or who has failed to comply with the diagnostic examination requirements of N.J.A.C. 8:57-5.5;

3. A person with active TB who has not complied with an order for DOT. Compliance is defined as keeping 80 percent of DOT appointments;

4. A person with active TB who has clearly expressed non-compliance with a prescribed treatment regimen. This may include, but is not limited to, refusal to cooperate with clinical staff during examination or voiced intent not to cooperate with diagnosis or treatment;

5. A person with infectious TB who is unable or unwilling to comply with a prescribed treatment regimen and infection control requirements;

6. A person with MDR-TB who is unable or unwilling to comply with infection control requirements; or

7. Where the Commissioner has determined that the public health, or the health of any other person, is endangered by a case of tuberculosis or suspected case of tuberculosis.

(b) Persons detained under this section shall be given a notice of the reasons for the detention and the opportunity for a hearing pursuant to N.J.A.C. 8:57-5.8, and due process in accordance with N.J.A.C. 8:57-5.9.

8:57-5.8 Hearing process

(a) The local health officer may remove to or detain in a hospital, detention facility, or detention unit a person who is the subject of a local health officer's order issued under N.J.A.C. 8:57-5.7, without prior court order, in accordance with N.J.S.A. 26:4-2e. If a person detained under such an order requests release, the local health officer shall make an application for a court order authorizing such detention within three business days after such request, in accordance with N.J.S.A. 30:9-57. After any such request for release, detention shall not continue for more than five business days without a court order. In no event shall any person be detained for more than 60 days without a court order authorizing such detention. The local health officer shall seek further court review of such detention within 90 days of the original court order. The local health officer shall seek further court review within 90 days of each subsequent court order.

(b) In any court proceeding under (a) above the local health officer seeking detention shall prove each required element for such detention by clear and convincing evidence.

(c) The required elements for an order issued under this section are:

1. A statement of the legal authority under which the order is issued;

2. Documentation of medical evidence indicating the presence of active TB and an assessment of the person's medical condition;

3. An individualized assessment of the person's circumstances and/or behavior constituting the basis for the issuance of the order; and

4. Documentation of the less restrictive treatment alternatives that were attempted and were unsuccessful and/or the less restrictive treatment alternatives that were considered and rejected, and the reasons such alternatives were rejected.

8:57-5.9 Due process

(a) At any hearing conducted pursuant to this subchapter, a person shall have the following due process rights:

1. Written notice detailing the grounds and underlying facts of the matter;

2. The right to counsel and, if indigent, the right to appointed counsel;

3. The right to be present at a court hearing; and to cross examine, and to present witnesses, which rights may be exercised through telecommunication technology;

4. The right to a verbatim transcript of the proceeding, if requested for the purposes of appeal; and

5. The right to a hearing in camera, if requested.

(b) The standard of evidence in any proceeding held under this subchapter is clear and convincing evidence.

8:57-5.10 Discharge plan

(a) When the medical director of the detention facility or his or her designee has determined that a person no longer poses a reasonable risk of transmitting any form of TB and that the person is able and willing to comply with his or her discharge plan, defined below, the medical director of the detention facility or his or her designee shall, within 24 hours, request the local health officer or the court who issued the detention order to terminate the detention order. This request shall include a copy of the discharge plan. The determination that a person no longer poses a reasonable risk of transmitting TB shall be based on the following factors:

1. Three consecutive negative sputum smears taken at medically appropriate intervals; and
2. Significant reduction of symptoms.

(b) The local health officer, in consultation with the Chief of the TB Control Program, shall determine whether the discharge and the discharge plan are acceptable within three days of receiving notice under this subsection. This determination shall be based on the principle of least restrictive alternatives and take into account the medical and social resources available to the person. This determination shall be provided to the medical director of the detention facility in writing and shall include the reasons for approving or denying the discharge and discharge plan.

(c) The local health officer shall keep the discharge plan on file.

(d) The discharge plan shall, at a minimum, provide the name and address of the person; a detailed description of the prescribed case management plans; a description of the person's living situation, including, but not limited to, source of support, persons living in the same household, next of kin, and arrangements with community organizations; and the name and address of a health care provider(s) who will provide necessary care, including, but not limited to, assignment of a case manager, clinical case management, DOT and other services necessary to implement the prescribed treatment plan. The discharge plan shall include at least one scheduled appointment with the health care provider(s).

8:57-5.11 Detention facilities

(a) The Commissioner shall designate sufficient detention facilities or units of facilities from among those facilities submitting proposals in accordance with (b) below.

(b) Proposals shall include at least the following:

1. Medical services available to TB patients, including diagnostic services and medical care for non-TB related illnesses;
2. The qualifications of professional medical staff providing services to TB patients;
3. The security plan, policies and procedures for proposed TB services;
4. A quality assurance plan for TB services; and
5. A location for court hearings.

(c) Within 60 days of the adoption of these rules, the Commissioner shall issue a request for proposals for designation as a detention facility or detention unit of a facility.

(d) The Commissioner shall consider the following in designating detention facilities or units:

1. The geographic incidence and prevalence rates of TB;
2. The quality and appropriateness of the proposed TB service;
3. Costs and financial viability of the facility or units; and
4. Other criteria identified in the request for proposals.

8:57-5.12 Procedures for detention by local health officers

(a) The local health officer may request assistance from the local police department(s) if the local health officer determines that there is a reasonable likelihood that a person will attempt to avoid detention based on an order issued pursuant to N.J.A.C. 8:57-5.7.

(b) If assistance is requested, the local health officer shall provide the police with the order under which the detention is authorized. The police may provide necessary assistance before receiving a copy of the order.

(c) If assistance is requested, the local health officer shall inform the police department of the name, address or last known location, and a description of the physical characteristics of the person.

(d) The local health officer shall develop, in consultation with the local police department, a protocol for police assistance which includes the types of assistance which may be requested of the local police department and guidance on appropriate situations for use of emergency medical service personnel.

8:57-5.13 Annual report

The Chief of TB Control Program shall submit to the Commissioner an annual report describing trends in prevalence and incidence of TB and MDR-TB in New Jersey. The report shall also include descriptive statistics showing the frequency and trends of those Reportable Events listed in N.J.A.C. 8:57-5.3. The first report shall be issued 12 months after the effective date of these rules and subsequent reports shall be due yearly after that date.

8:57-5.14 Confidentiality of records

(a) Medical or other information included in the case record(s) about any person subject to these rules, or information concerning reportable events pursuant to any section of these rules, shall not be disclosed except under the following circumstances:

1. For research purposes, provided that the study is reviewed and approved by applicable health care facility, State and Federal review boards and is done in a manner that does not identify any person, either by name or other identifying data element;
2. With written consent of the person identified;
3. When the Commissioner determines that such disclosure is necessary to enforce public health laws or to protect the life or health of a named party, in accordance with applicable State and Federal laws; or
4. Pursuant to a valid court order.

(b) Any public employee who violates this rule is subject to disciplinary action, which may include termination by the employing agency. Non-public employees who violate this subsection are subject to the penalty provisions of N.J.A.C. 8:57-5.17.

8:57-5.15 Mandatory exclusion from workplace or school

(a) The local health officer may, pursuant to this subsection, order that a person with known infectious TB shall be excluded from attending his or her place of work or school, or shall be excluded from other premises, where the local health officer determines, after a review of the facts and circumstances of the particular case, that such an action is necessary to protect others from the spread of the disease.

(b) If a person excluded from a work place or school, in accordance with N.J.S.A. 26:4-2, requests a review of the order, the local health officer shall make an application for a court order authorizing such exclusion within three business days after such request. After any such request, exclusion shall not continue more than five business days without a court order. In no case shall a person be excluded from a workplace, school or other premises for more than 60 days without a court order authorizing such exclusion. The local health officer shall seek further court review of such exclusion within 90 days of the original court order or each subsequent court order.

(c) In any court proceeding under (b) above, the local health officer shall prove each required element for such exclusion by clear and convincing evidence.

(d) The required elements for an order issued by a local health officer under this section are:

1. A statement of the legal authority under which the order is issued;
2. Documentation of medical evidence indicating the presence of infectious TB and an assessment of the person's medical condition;
3. An individualized assessment of the person's circumstances and/or behavior constituting the basis for the issuance of the order; and
4. The less restrictive alternatives that were attempted and/or the less restrictive alternatives that were considered and rejected, and the reasons such alternatives were rejected.

(e) The local health officer shall revoke the order for exclusion based on the following elements:

1. A health care provider's documentation that the patient had three negative sputum smears at clinically appropriate intervals and a significant reduction of clinical symptoms; and
2. If deemed necessary by the local health officer, independent review by another health care provider.

8:57-5.16 Authority of other local health officers

(a) Unless otherwise indicated, the local health officer who has primary responsibility under these rules is the local health officer of the jurisdiction in which the person subject to these rules resides.

(b) Local health officers in areas where the person frequents or receives care may take any action authorized under these regulations if the local health officer determines that they are necessary for the health of the person or the public. Such local health officers shall notify the local health officer with primary responsibility, within 72 hours, of any actions taken under these regulations.

8:57-5.17 Penalties for violation of rules

A person who fails to adhere to any provision of these rules shall be subject to a fine of $50.00 for the first infraction and $100.00 for the second and any subsequent infractions. Fines shall be recoverable pursuant to the Penalty Enforcement Act (N.J.S.A. 2A:58-1 et seq.). All violations by health care providers shall be reported to the appropriate professional licensing authorities and public financing programs.

HIGHER EDUCATION

(a)

NEW JERSEY HIGHER EDUCATION ASSISTANCE AUTHORITY (NJHEAA)

Eligibility Criteria for NJCLASS Loans

Proposed Amendments: N.J.A.C. 9:9-7.1, 7.2 and 7.3

Authorized By: New Jersey Higher Education Assistance Authority, Warren E. Smith, Chairman.
Authority: N.J.S.A. 18A:72-10.
Proposal Number: PRN 1994-462.

Submit comments by September 14, 1994 to:
Laura M. Rivkin
Assistant Director of Policy and Planning
New Jersey Higher Education Assistance Authority
4 Quakerbridge Plaza—CN 540
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The New Jersey Higher Education Assistance Authority (NJHEAA) is statutorily responsible for the administration of Federally guaranteed loan programs in New Jersey and the New Jersey College Loans to Assist State Students Loan Program (NJCLASS). N.J.S.A. 18A:72-1 et seq. The NJHEAA proposes to amend the rules governing eligibility for NJCLASS loans for several reasons: consistency with recent changes in relevant provisions of the Higher Education Act of 1965 and United States Department of Education (ED) regulations issued thereunder, consistency with broadened access and fiscal stability policies underlying the NJCLASS program, and clarity of eligibility criteria.

The NJHEAA proposes to amend N.J.A.C. 9:9-7.1(a) by expanding the definition of "parent borrower" so that it includes "other relative," simplifying the definition of "eligible collegiate institution," and adding the definitions of "co-signer" and "reaffirmation." The changes would be consistent with NJCLASS policy of increasing access to higher education by expanding the class of eligible borrowers, and at the same time, ensuring fiscal stability of the program by not tilting the class toward borrowers who are not creditworthy.

The NJHEAA proposes to amend N.J.A.C. 9:9-7.2(a) by deleting language dealing with the discharge of student loans and adding language focusing on financial reasons for ineligibility and the criteria for creditworthiness set forth in the NJCLASS loan application. The rationale for this change is to avoid excluding applicants who have had loans discharged for non-default reasons (for example, closed school), and to focus the issue of eligibility on the financial criteria for creditworthiness set forth in the NJCLASS application.

The NJHEAA also proposes a change to N.J.A.C. 9:9-7.2(a) to increase the access to NJCLASS loans for applicants with prior Federal Family Education Loans (FFEL) or NJCLASS loans discharged by reason of total and permanent disability, as defined in 34 CFR 682.200. This change incorporates two NJHEAA policies: (1) the belief that qualified students with disabilities are entitled to equal access to financial aid available to the general student population; and (2) the belief that NJCLASS applicants must be creditworthy. NJCLASS loans are intended to assist students to attend school. They are not intended to permit applicants whose FFEL loans were discharged by reason of total and permanent disability to avoid their Federal obligations by borrowing under a State program.

Accordingly, the NJHEAA proposes to add language to N.J.A.C. 9:9-7.2(a) to ensure that the appropriate beneficiaries have access to NJCLASS loans. Applicants or students (students on whose behalf another borrower is applying for a NJCLASS loan) with prior loans discharged by reason of total and permanent disability would be permitted access to NJCLASS loans by reaffirming the prior debt and by obtaining a certification from a physician that the applicant's or student's condition has improved and that the applicant or student is able to engage in substantial gainful activity. These two steps closely mirror requirements for FFEL eligibility set forth in 34 CFR 682.201. For consistency with FFEL eligibility, NJHEAA also proposes to add United States citizenship/permanent resident status requirements to N.J.A.C. 9:9-7.2(a) and (b). As a result of these added provisions, N.J.A.C. 9:9-7.2(a)1 through 3 and (b)1 through 3 are recodified.

The NJHEAA proposes to amend N.J.A.C. 9:9-7.2(b) and 7.3(a) to clarify the supplemental nature of the NJCLASS program. N.J.A.C. 9:9-7.2(b) is also amended to reflect the change of name from "Federal Stafford Loan" to "Federal Family Education Loan," as provided in the Higher Education Amendments of 1992, effective July 23, 1992.

Social Impact

The proposed amendments ensure that NJCLASS loans will be available to a broadened class of borrowers to assist in the financing of higher education costs without compromising the fiscal stability of the program or the purposes of the program to supplement the FFEL program.

Economic Impact

Because of the reasons given under the Social Impact above, the proposed amendments are expected to provide a clear economic benefit to students by ensuring greater access to NJCLASS loans while imposing no economic burden on the NJCLASS program.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments do not impose reporting, recordkeeping or other compliance requirements on small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:13B-16 et seq. The proposed amendments impact individual loan recipients and the Authority only.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

9:9-7.1 Definitions

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

...

"Co-signer" means an individual who signs a promissory note and agrees to repay the loan in the event the borrower does not.

"Eligible collegiate institution" or "school" or "college" means a college or university approved or licensed by the State [Board of Higher Education] or accredited by a regional accrediting association recognized by the Council on Postsecondary Accreditation and having a New Jersey cohort default rate of 20 percent or less.

...

"Parent borrower" means a parent(s), spouse, [or], legal guardian **or other relative** of a dependent undergraduate or graduate student.

...

"Reaffirmation" means the acknowledgment of the loan by the borrower or co-signer in a legally binding manner.

...

(b) (No change.)

9:9-7.2 Eligibility

(a) To be eligible for a NJCLASS loan, each applicant must:

1. Be a citizen, national or legal resident of the United States or be in the U.S. for other than temporary purposes and intend to become a permanent resident (as evidenced by Immigration and Naturalization Service documentation);

[1.]**2.** Be a permanent resident of New Jersey for at least six months prior to filing a NJCLASS application;

[2.]**3.** Not be in default on any student loan or [had any student loan discharged] **in violation of any of the other criteria for determining creditworthiness as set forth in the NJCLASS application;** [and]

[3.]**4.** Provide an acceptable co-signer if it is determined by the Authority that one is required[.]**; and**

5. Reaffirm any Federal Family Education Loan amount or any NJCLASS loan amount that previously was cancelled due to the applicant's total and permanent disability and obtain a certification from a physician that the applicant's condition has improved and that the applicant is able to engage in substantial gainful activity. If the applicant is not the student, the student on whose behalf another borrower is applying for a NJCLASS loan must reaffirm any Federal Family Education Loan amount or any NJCLASS loan amount that previously was cancelled due to the student's total and permanent disability and obtain a certification from a physician that the student's condition has inproved and that the student is able to engage in substantial gainful activity.

(b) In addition to all of the requirements in (a) above, a student applicant or a student on whose behalf the parent and/or borrower is applying for a NJCLASS loan shall:

1. Be a citizen, national or legal resident of the United States or be in the U.S. for other than temporary purposes and intend to become a permanent resident (as evidenced by Immigration and Naturalization Service documentation);

[1.]**2.** Have a high school diploma or a high school equivalency certificate;

[2.]**3.** Be enrolled or accepted for enrollment on at least a [half-time] **part-time** basis in an eligible school;

[3.]**4.** If currently enrolled in an eligible school, be determined by the school to be making satisfactory academic progress [in a degree or certificate program]; and

[4.]**5.** Have exhausted **eligibility for** or be ineligible for [subsidized] Federal [Stafford] **Family Education** Loans, **and other forms of student assistance, excluding PLUS loans or student assistance under subpart I or part C of title VII of the Public Health Service Act.**

9:9-7.3 Loan amounts

(a) The amount borrowed shall not exceed a student's estimated cost of attendance at the eligible school minus all other financial assistance [received by the student] **for which the student is eligible (excluding PLUS loans or student assistance under subpart I or part C of title VII of the Public Health Service Act)** for the academic period for which the loan is intended.

(b) The minimum amount which may be borrowed is $500.00.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS

Motor Vehicle Leasing

Proposed New Rules: N.J.A.C. 13:45A-28

Authorized By: James Mulvihill, Assistant Attorney General in Charge, Division of Consumer Affairs.

Authority: N.J.S.A. 56:8-4 and 56:12-50 et seq., specifically, 56:12-55.

Proposal Number: PRN 1994-469.

Submit written comments by September 14, 1994 to:

James F. Mulvihill,
Assistant Attorney General in Charge
Division of Consumer Affairs
Post Office Box 45027
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Division of Consumer Affairs is proposing new subchapter N.J.A.C. 13:45A-28, Motor Vehicle Leasing, in order to implement the "Truth in Motor Vehicles Leasing Act," P.L. 1993, c.328 (N.J.S.A. 56:12-50 et seq.) (the "Act"). The new rules set forth both disclosure requirements and certain requirements that pertain to leasing practices, such as payment or trade-in pending execution of lease agreement, security deposit, end of term liability, and reinstatement. The new rules will in their entirety enable consumers to be better served by motor vehicle leasing transactions, which are unmatched in their complexity by any other ordinary consumer transaction.

N.J.A.C. 13:45A-28.1 sets forth the purpose and scope of these rules, and N.J.A.C. 13:45A-28.2 provides definitions. N.J.A.C. 13:45A-28.3 delineates those individuals engaging in the business of motor vehicle leasing who need to be licensed pursuant to N.J.S.A. 39:10-19, including anyone who in the course of any 12-month period offers to lease or leases in New Jersey more than three motor vehicles.

N.J.A.C. 13:45A-28.4, Notification, lease disclosure statement, sets forth the information to be contained in a lease agreement in order to ensure that consumers who choose to lease a motor vehicle are sufficiently conversant with the details of the contractual obligations that they will be assuming. The requirements of this section can be categorized as follows:

Certain provisions require the disclosure of information deemed essential to a complete lease disclosure statement, including motor vehicle year, make, model and operational features; prior usage should the odometer be in excess of 300 miles; the names and addresses of all parties to the lease agreement; the total cost to the consumer upon early termination of the lease; and all other fees and charges for which the consumer may be liable under the terms of the lease.

Other provisions require disclosure to emphasize crucial lease details and to avoid situations in which consumers claim to have signed the agreement without knowing its most basic terms. Accordingly, subsection (e) requires that the lease provide in at least 10-point bold type in the space immediately preceding the lessee's signature the total cost of the lease, the periodic or monthly payment, and any purchase option price.

Finally, this section on disclosure sets forth a select number of injunctions. One is that the lessors may charge only for fees and charges disclosed in advance. Another concerns liability of the lessee in the event the motor vehicle is determined to be a total loss prior to the lease termination date (gap liability). Lessors must explain the consumer's gap liability in simple, clear, easily readable language, and set forth any option the consumer may have to pay for a gap waiver. Other injunctions include the following: the lease agreement may contain blank spaces provided that such spaces are immediately followed by language explaining that if no amount is inserted, a specific cost or rate will be applied; the lease may not contain a waiver by the consumer of claims the consumer may have against the dealer or lessor; and the lease must comply with the Plain Language Law.

N.J.A.C. 13:45A-28.5, Payment or trade-in pending execution of lease agreement, is being proposed to guard against instances in which consumers have apparently been given to understand that they have a finalized lease agreement, only to discover that their lease was contingent on credit approval. If such approval is withheld, consumers suffer both the logistical inconvenience of finding themselves without the "leased" motor vehicle and the expense of paying a rental fee for the time that they drove the motor vehicle. To avoid other instances in which consumers denied credit approval claim to have been told that they might retain the already "leased" vehicle provided they agreed to more onerous lease terms, this section prohibits the lessor from conveying possession of the motor vehicle to the consumer until all contract contingencies have been met.

N.J.A.C. 13:45A-28.6, End of term liability; security deposit, addresses the end of lease term liability settlements (that is, excess wear or damage claims) that result in disputes between the lessor and lessee and instances in which a consumer's security deposit is not returned in a timely manner. According to complainants, lessors allege wear or damage claims of a

magnitude that strikes consumers as unfair and often even as a coercive incentive for them to "flip" or agree to another lease so as to avoid or negotiate a reduction of the lessor's claims. For their part, lessors maintain that consumers frequently fail to take adequate care of leased vehicles and leave the lessor with no choice but to assert such excess wear or damage claims in order to compensate for the vehicle's reduced value.

Accordingly, this section sets forth a method for resolving disputed excess wear or damage claims and for the return of the consumer's security deposit pursuant to such resolution. Prior to charging, receiving or collecting an assessment for excess wear or damage, the lessor must inform the consumer in writing of the consumer's right to obtain a second itemized estimate, without which the lessor's estimate will be considered valid after 10 days. If the initial itemized estimate is challenged by the consumer, the consumer has 15 additional days in which to secure a second itemized estimate. Should the evidence provided by these two estimates fail to provide the basis on which the lessor and consumer can reach settlement as to what constitutes reasonable wear and damage claims, then an action may be filed in Superior Court by either party.

N.J.A.C. 13:45A-28.7, Reinstatement, enables a consumer who has been in default of payment only once during the course of a lease to be reinstated provided that all past due periodic payments, late fees and costs associated with any repossession will be paid by the consumer to the lessor. Otherwise reliable consumers will be able to maintain the continuity of their lease while lessors will be able to both retain a business relationship with the consumer and to ensure that reinstatement will not become an avenue to assuming unreasonable risks.

N.J.A.C. 13:45A-28.8, Regulation M; Consumer Fraud Act, sets forth that a violation of either Federal regulation M (which addresses leasing) or the New Jersey Consumer Fraud Act is a violation of the Truth in Motor Vehicles Leasing Act.

Social Impact

Some leasing industry analysts have projectd that by the end of the century, half of all new motor vehicles on the market in this country will be leased rather than sold to consumers. Thus the social impact of these motor vehicle leasing rules (which are the first to be implemented in any state) promises to be significantly beneficial to consumers, while also clarifying for lessors their obligations and rights under the Act. Due to the disclosure requirements contained in N.J.A.C. 13:45A-28.4, consumers will be assured of receiving specific essential information in terms the consumer can readily understand in order to facilitate better informed decision making.

N.J.A.C. 13:45A-28.5 will safeguard consumers against repossession of the vehicle due to denied credit approval.

N.J.A.C. 13:45A-28.6 is expected to ensure the timely return of a consumer's security deposit and have the not coincidental social benefit to consumers of reaffirming their opportunity to secure a second itemized estimate in those instances in which they consider the lessor's original estimate to be egregious.

N.J.A.C. 13:45A-28.7 is expected to be socially beneficial to consumers by ensuring that they will be allowed to be reinstated once during the term of the lease should they be in default of periodic payment.

Economic Impact

N.J.A.C. 13:45A-28.4 will have an economic impact on lessors to the extent that these disclosure standards will require revision of lease contracts. To minimize any expense that disclosure compliance may entail, prior usage may be disclosed by use of check-off boxes designating categories such as demonstrator, taxi, daily rental, police, prior wreckage or unknown. Similarly, disclosures required by subsection (e) must be in typeface that is at least 10-point bold in order to provide a standard reasonable to lessors while simultaneously beneficial to consumers.

N.J.A.C. 13:45A-28.5 may have a beneficial economic impact on consumers by protecting them against instances in which denied credit approval means that they will, in effect, have to pay a rental fee for the vehicle that they had presumably leased.

N.J.A.C. 13:45A-28.6 is expected to be economically beneficial to consumers in terms of its overall impact because it reminds them that they have the recourse of obtaining a second itemized estimate if confronted with seemingly egregious excess wear and damage claims based on the lessor's original itemized estimate. Consumers who choose to obtain a second itemized estimate will, however, typically need to expend approximately $100.00.

This section will also have an economic impact on those lessors who do not already validate their claims with an itemized estimate provided by an unaffiliated appraiser or autobody shop licensed in the state of New Jersey and who will thus be required to secure such an estimate at a typical cost of $65.00. Furthermore, this section will have an economic impact on all lessors in that they will be required to hold the motor vehicle in question for an additional 15 days if the consumer chooses to arrange for a second itemized estimate.

The costs cited above may not necessarily be incurred, however, since an auto-body shop will frequently not charge for an estimate provided that the repair work upon which that estimate is based is performed there. Accordingly, either the consumer or the lessor may not need to incur the expense of an itemized estimate (based on which of the two auto-body shops is authorized to perform repairs related to the settlement of an excessive wear or damage claim).

N.J.A.C. 13:45A-28.7 is expected to have a nominal economic impact on lessors in that if they do not choose to personally deliver to the defaulted consumer a notice that he or she has an opportunity for reinstatement, then such notice must be sent by both first-class and certified mail.

Regulatory Flexibility Analysis

New Jersey has approximately 750 dealerships and 100 independent licensing companies engaged in the business of leasing motor vehicles. Since, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., all of these dealerships and companies are likely to be deemed "small businesses," then within the meaning of the statute the following statement is applicable:

N.J.A.C. 13:45A-28.4 is expected to result in professional service costs for lessors who need to bring their lease agreements into compliance with the proposed disclosure standards and who may retain the services of legal counsel in order to do so. Costs will necessarily vary depending on the degree to which the lessor's current lease agreement reflects the disclosure standards embodied in this proposal and on the going rate for the services of the legal counsel that a lessor may retain for this purpose.

N.J.A.C. 13:45A-28.6 will involve other professional costs for lessors, who may now for the first time need to arrange for either an unaffiliated appraiser or an auto-body shop licensed in the State to provide an itemized estimate of excess wear or damage to the leased motor vehicle. This section may also involve other costs of compliance because lessors will, in instances of a contested estimate, need to retain the motor vehicle for 15 days so that the consumer may arrange for a second itemized estimate.

N.J.A.C. 13:45A-28.7 may involve other nominal costs of compliance for lessors in that if they do not choose to personally deliver to the defaulted consumer a notice that he or she has an opportunity for reinstatement, then such notice must be sent by both first-class and certified mail.

The Office of Consumer Protection considers these provisions to be reasonable and to be the minimum necessary in order to be in compliance with the "Truth in Motor Vehicles Leasing Act" and to protect consumers. Therefore, these provisions must be uniformly applied to all independent leasing companies and new car dealerships engaged in motor vehicle leasing without differentiation as to size of practice.

Full text of the proposed new rules follows:

SUBCHAPTER 28. MOTOR VEHICLE LEASING

13:45A-28.1 Purpose and scope

(a) This subchapter implements the "Truth in Motor Vehicles Leasing Act," P.L. 1993, c.328 (N.J.S.A. 56:12-50 et seq.) (the "Act").

(b) This subchapter is applicable to any person who in the ordinary course of business is engaged in New Jersey in the leasing of motor vehicles or who in the course of any 12-month period offers in New Jersey more than three motor vehicles for lease.

13:45A-28.2 Definitions

As used in this subchapter or in the Act, the following words shall have the following meanings:

"Day" means a calendar day, except that where a period of time ends on a Sunday or holiday, the last day of that period shall be the next business day.

"Dealer" means a person who, in the ordinary course of business, is engaged in New Jersey in the leasing of motor vehicles or who in the course of any 12-month period offers to lease or leases in New Jersey more than three motor vehicles.

"Disposition fees" means fees imposed if the lessor has to dispose of the vehicle either at early termination or upon scheduled termination of the lease.

"End of the term of the lease" means the scheduled termination of the lease and not early termination resulting from, for example, a lessee default or the lessee's purchase of the vehicle prior to the scheduled termination of the lease.

"Excess wear or damage" means wear or damage beyond that expected to be incurred in normal circumstances.

"Gap liability" means the liability of the lessee in the event the motor vehicle is determined to be a total loss or stolen and not recovered prior to the lease termination date.

"Lease" means a contract or other agreement between a lessor and a lessee for the use of a motor vehicle by the lessee for a period of time exceeding 60 days, whether or not the lessee has the option to purchase or otherwise become the owner of the motor vehicle at the end of the term of the lease.

"Lessee" means a person who leases a motor vehicle.

"Lessor" means a dealer who holds title to a motor vehicle leased to a lessee or a person who holds all of the lessor's rights under the lease. Any person merely holding a security interest in a lease shall not constitute a lessor.

"Motor vehicle" means a passenger automobile or motorcycle as defined in N.J.S.A. 39:1-1 which is or could be registered by the Division of Motor Vehicles in the Department of Law and Public Safety, except the living facilities of motor homes.

"Person" means an individual, corporation, partnership or other entity.

"Purchase option price" means the amount the lessee will be required to pay by contract for purchasing the leased motor vehicle at the end of the lease term, excluding taxes.

"Regulation M" means Federal Reserve Board Regulation M, 12 C.F.R. Part 213, as amended.

"Residual value" means the reasonable estimate of fair market value of the motor vehicle at the end of the lease term.

13:45A-28.3 Licensure

(a) The following persons shall be licensed pursuant to N.J.S.A. 39:10-19. A person who:

1. In the ordinary course of business, is engaged in New Jersey in the leasing of motor vehicles; or

2. In the course of any 12-month period, offers to lease or leases in New Jersey more than three motor vehicles.

(b) This section shall not apply to assignees of lease contracts who purchase such contracts from licensed entities.

13:45A-28.4 Notification, lease disclosure statement

(a) Every lease shall be in writing, shall contain the entire agreement between the lessor and the lessee and shall be signed by the lessor and lessee. The lease shall conform both to the Act and to Regulation M. All dislcosures required by the Act and this subchapter shall be contained either in the lease or an addendum to the lease, or both.

(b) The lease shall provide the following information concerning the motor vehicle to be leased:

1. Year;
2. Make;
3. Model;
4. The motor vehicle identification number (VIN);
5. Any dealer-installed options;
6. Whether the motor vehicle has air conditioning;
7. Whether the motor vehicle has automatic or manual transmission;
8. The name, address and telephone numbers of all parties to the lease on the date that the lease is executed;
9. As applicable, the name, address and telephone number of the party to whom the lease has been assigned; and
10. If the odometer reads in excess of 300 miles, an explanation of the prior use of the motor vehicle using the following terms, as applicable: demonstrator, taxi, daily rental, police, prior wreckage, unknown; provided that the lessor may insert "unknown" only if, in the exercise of reasonable diligence, the lessor does not know or could not reasonably determine the prior use of the motor vehicle.

(c) The lease shall be identified with the term "lease," "motor vehicle lease" or "lease agreement" in at least 14-point bold type in the heading of the lease agreement.

(d) The lease shall contain a full disclosure of the formula the lessor will use to calculate the total cost to the lessee if the lessee terminates the lease at any time prior to the end of the term of the lease.

(e) The lessor shall not impose any fees or charges unless such fees and charges are specifically disclosed, by dollar amount, method of imposition or formula, at the inception of the lease. Such fees and changes include, but are not limited to:

1. Repossession costs;
2. Collection costs;
3. Disposition fees;
4. Excessive wear or use;
5. Parking and other violations; and
6. Taxes.

(f) The lease shall set forth in simple, clear, and easily readable language the lessee's gap liability, if any, under the Act and any offer by the lessor (which may be for a separate or additional charge) to waive future gap liability. Any gap waiver may be on such terms and conditions and contain such exclusions as the lessor and lessee may agree (for example, deductible amount, past due payments, etc.).

(g) The lease shall provide the following information in at least 10-point bold face type in the space immediately preceding the lessee's signature:

1. "TOTAL COST OF THE LEASE," using that term, which shall be exclusive of the purchase option price, as defined in Section 3g(6) of the Act (N.J.S.A. 56:12-52g(6);

2. "PERIODIC PAYMENT," "MONTHLY PAYMENT" or other designated payment period for leasing the motor vehicle, including use or sales tax if applicable; and

3. If an option to purchase the motor vehicle at the end of the lease is provided to the lessee, the "PURCHASE OPTION PRICE," using that term. If an option to purchase prior to the end of the lease is also provided, the lessor may disclose that information in connection with the disclosure of the PURCHASE OPTION PRICE.

(h) The dollar amounts applicable to each of the required disclosures in (e) above shall be in not less than 10-point size typewritten numerals or shall be legibly handwritten.

(i) The lease may contain blank spaces, provided that such spaces are immediately followed by language explaining that if no amount is inserted, a specific cost or rate will be applied, for example, "the cost per excess mile is $.__, but if no amount in inserted the cost is $.12 per mile."

(j) A lease shall not contain a waiver by the lessee of any claims the lessee may have against the dealer or lessor.

(k) The lease shall comply with the Plain Language Law, N.J.S.A. 56:12-1 et seq.

13:45A-28.5 Payment or trade-in pending execution of lease agreement

The lessor shall not convey possession of the motor vehicle to the lessee until all contract contingencies have been met.

13:45A-28.6 End of term liability; security deposit

(a) The lessor shall not charge, receive or collect an assessment for excess wear or damage unless the lessor complies with the provisions of this section.

(b) Within 15 days of the end of the term of the lease, the lessor shall provide the lessee with the following:

1. An itemized estimate conforming with (c) below from an unaffiliated appraiser or an auto-body shop licensed in the State of New Jersey;

2. Written notice of the lessee's right to obtain a second itemized estimate;

3. Written notice that the lessor's estimate will be considered valid unless the lessee contests the estimate in writing within 10 days of the postmarked date of the lessor's correspondence; and

4. An itemized statement of the original security deposit and the amount thereof claimed.

(c) The lessor shall immediately return to the lessee any portion of the lessee's security deposit that is not being claimed based on the lessor's itemized estimate of excess wear or damage.

(d) The lessor's estimate shall state the lower of the following two amounts:

1. The lessor's actual costs, reduced by all discounts, for repairing the excess wear or damage; or

2. The decrease in value of the motor vehicle due to the excess wear or damage.

(e) Within 10 days of the postmarked date of the lessor's correspondence, the lessee shall notify the lessor in writing of his or her intention to contest the lessor's itemized estimate.

(f) Within 15 days of such notification, the lessee shall provide the lessor with the second itemized estimate from an unaffiliated appraiser or an auto-body shop licensed in the State of New Jersey.

(g) Should the lessee contest the lessor's itemized estimate, the lessor shall retain possession of the vehicle and shall allow the lessee and his or her appraiser reasonable access thereto for the purpose of obtaining the second itemized estimate.

(h) Should the lessor and lessee subsequently fail to agree as to what constitutes a fair charge for any claims of excess wear or damage, either or both parties may then file an action in Superior Court.

(i) Within five days of the final determination of liability, the lessor shall return to the lessee any unused portion of the security deposit.

13:45A-28.7 Reinstatement

(a) If a lessee is 30 or more days in default of the periodic payments due on the lease and the lessor wishes to cancel the lease, the lessor shall personally deliver to the lessee or send by both first-class and certified mail, at the lessee's last known address as shown on the records of the lessor, a notice of reinstatement. The notice of reinstatement shall clearly and conspicuously advise that the lessee has 15 days to reinstate the lease by paying all past due periodic payments, late fees and, if the motor vehicle has been repossessed, the costs to the lessor of repossessing, transporting and storing the motor vehicle.

(b) Upon payment within the 15-day period to the lessor of the amounts due, the lease will be reinstated as if the lessee had not been in default of payment.

(c) The lessor shall not be required to reinstate a lessee more than once during the term of the lease.

(d) The lessee shall waive the right to reinstatement if the motor vehicle has been seized or an action for its seizure and/or forfeiture has been commenced by any governmental agency or authority under color of any state or Federal law or regulation, or if the lessee is in default based on failure to insure the vehicle.

(e) The right of reinstatement does not apply to existing lease contracts signed by the lessee prior to the implementation of these regulations.

13:45A-28.8 Federal regulation M; Consumer Fraud Act

(a) A violation of Federal Regulation M, 12 CFR Ch. 11, Section 213.1 et seq., shall constitute a violation of the Act.

(b) It is an unlawful practice and a violation of the Consumer Fraud Act, P.L. 1960, c.39 (N.J.S.A. 56:8-1 et seq.) to violate any provision of the Act or of these implementing rules.

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

New Jersey Bridge Rehabilitation and Improvement Fund: State Aid to Counties and Municipalities

Proposed Readoption: N.J.A.C. 16:21A

Authorized By: W. Dennis Keck, Acting Assistant Commissioner for Policy and Planning.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:7-13, 7-47 and the New Jersey Bridge Rehabilitation and Improvement Bond Act of 1983, P.L. 1983, c.363.

Proposal Number: PRN 1994-464.

Submit comments by September 14, 1994 to:

Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Under the "sunset" and other provisions of Executive Order No. 66(1978), N.J.A.C. 16:21A, New Jersey Bridge Rehabilitation and Improvement Fund: State Aid to Counties and Municipalities, will expire on November 20, 1994. The rule was proposed as new rules upon expiration with technical changes at N.J.A.C. 16:21A-1.3, which appeared at 21 N.J.R. 3674(a); effective November 20, 1989. During the five years of operation, the Department has experienced no problems or controversy with the rules as was amended.

These rules were proposed to implement provisions and purposes of the New Jersey Bridge Rehabilitation and Improvement Bond Act of 1983, P.L. 1983, c.363, effective October 4, 1983. The Department in compliance with the provisions of the Bond Act and applicable rules must ensure and maintain a safe and reliable transportation system. Additionally, a safe and reliable system of rail and road transportation is essential to the well-being of the citizens and the economy of the State.

The funds under the Act were appropriated by the Legislature as the State's share of the cost for construction, reconstruction, replacement, improvement, repair or rebuilding of bridges carrying county or municipal roads, including railroad overhead bridges. Although the funds from this Bond Act were appropriated in 1983, there remains a nominal sum of money that needs to be dispersed for projects that have not been completed. The Department is in the process of trying to close out these accounts; however, until such time, these rules need to be readopted once more so we can continue this program and close out these accounts.

The Bureau of Local Aid Highway Design has, therefore, reviewed these rules and has determined them to be necessary, reasonable, and proper for the purpose of which they were originally promulgated.

The subchapters are summarized as follows:

N.J.A.C. 16:21A-1 outlines the general provisions of the rules.

N.J.A.C. 16:21A-2 prescribes the responsibility of the local government in the preparation of plans and specifications.

N.J.A.C. 16:21A-3 provides the procedure to be followed in the awarding of contracts.

N.J.A.C. 16:21A-4 describes the cost sharing or cost participation by the responsible agency.

N.J.A.C. 16:21A-5 establishes guidelines concerning audits to be undertaken by counties and municipalities which are the recipients of State grants and aid programs and Federal pass-through funds.

The Department therefore proposes to readopt N.J.A.C. 16:21A in compliance with P.L. 1983, c.363, the New Jersey Bridge Rehabilitation and Improvement Bond Act of 1983.

Social Impact

The proposed readoption will continue to provide a source of revenues to the State and local government in the rehabilitation and improvement of bridges. The rules will also assist in providing a safe and reliable system of rail and road transportation which is essential to the well-being of the citizens and the economy of the State.

Economic Impact

The Department and local government will incur direct and indirect cost for its workforce in the processing of plans and specifications, cost of engineering, contractual agreements and cost sharing regarding the specific rehabilitation or improvement project. Audit costs incurred by the municipality will be borne by the municipality.

Regulatory Flexibility Statement

The proposed readoption does not place any bookkeeping, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules primarily affect counties and municipalities.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 16:21A.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Turn Prohibitions
Rising Sun Road (under State jurisdiction)
Bordentown Township, Burlington County
Proposed New Rule: N.J.A.C. 16:30-3.12

Authorized By: Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-123, 39:4-124, 39:4-125, 39:4-183.6, 39:4-198 and 39:4-199.1.

Proposal Number: PRN 1994-451.

Submit comments by September 14, 1994 to:
William E. Anderson
Manager
New Jersey Department of Transportation
Bureau of Traffic Engineering and Safety Programs
1035 Parkway Avenue
CN 613
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Department of Transportation proposes to establish a new rule at N.J.A.C. 16:30-3.12 concerning turning movements along Rising Sun Road (under State jurisdiction) to effect a two-way center lane for left turns only in Bordentown Township, Burlington County. This new rule has been codified in compliance with the Department's rulemaking format. The provisions of this new rule will improve the flow of traffic and enhance safety along the highway system.

This rule is being proposed in conjunction with the reconstruction of Rising Sun Road (under State jurisdiction) between Route I-295 and Old York Road, and a study made by the Department's Region III Design, that determined that a two-way center lane for left turns only, was warranted in the interest of traffic safety. The traffic investigations conducted by the Department's Bureau of Traffic Engineering and Safety Programs concluded that the establishment of the two-way center lane for left turns only restriction along Rising Sun Road in Bordentown Township, Burlington County, were warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed new rule will establish a center lane for left turns only along Rising Sun Road in Bordentown Township, Burlington County, to improve traffic safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The Department will bear the costs for the installation of the appropriate regulatory signs. The costs involved in the installation and procurement of signs vary, depending upon the material used, size and method of procurement. Motorists who violate the rules will be assessed the appropriate fine in accordance with the "Statewide Violations Bureau Schedule," issued under New Jersey Court Rule 7:7-3.

Regulatory Flexibility Statement

The proposed new rule does not place any reporting, recordkeeping or compliance requirements on small businesses as the term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed new rule primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

Full text of the proposed new rule follows:

16:30-3.12 Rising Sun Road

(a) Turning movements of traffic on certain parts of Rising Sun Road (under State jurisdiction) described in this subsection are regulated as follows:

1. In Burlington County:

i. In Bordentown Township:

(1) Center lane for left turns only:

(A) Both directions of Rising Sun Road (under State jurisdiction) beginning 800 feet east of the Route I-295 northbound exit ramp and extending to 500 feet west of Old York Road.

(b)

DIVISION OF TRANSPORTATION ASSISTANCE
OFFICE OF REGULATORY AFFAIRS

Zone of Rate Freedom
Proposed Amendment: N.J.A.C. 16:53D-1.1

Authorized By: W. Dennis Keck, Acting Assistant Commissioner, Policy and Planning.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 48:2-21 and 48:4-2.20 through 2.25.

Proposal Number: PRN 1994-463.

A **public hearing** concerning this proposal will be held on:
Thursday, September 1, 1994, at 1:00 P.M. to 3:00 P.M.
Multi-Purpose Room
New Jersey Department of Transportation
1035 Parkway Avenue
Trenton, New Jersey 08625

Submit written comments by September 14, 1994 to:
Ms. Renee Rapciewicz, Deputy Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, NJ 08625
(609) 530-2041

The agency proposal follows:

Summary

The proposed amendment at N.J.A.C. 16:53D-1.1 implements N.J.S.A. 48:4-2.20 through 2.25 which direct the Commissioner of the Department of Transportation to establish a Zone of Rate Freedom (ZORF) for the regular route private autobus carriers operating within the State. The ZORF constitutes a limited percentage range to be set annually by the Commissioner in which regular route private autobus carriers may be permitted to adjust their rates, fares or charges without petitioning the Department for prior approval. Provided the autobus carrier remains within the designated percentage range, all that is required is notice to the Department and the riding public of the rate, fare or charge adjustment prior to the effective date. If, however, the regular route autobus carrier seeks a percentage adjustment greater than that provided for in the ZORF, such autobus carrier will be required to follow the standard petitioning procedures, as specified in N.J.S.A. 48:2-21 and N.J.A.C. 16:51-3.10 and 3.11.

After extensive review of the ZORF and its relationship to regular route private autobus carrier costs, revenues and fare structures, the Department proposes to amend the current ZORF. The percentage limitations contained in the 1995 proposal are scaled in consideration of the varying fares currently charged by intrastate regular route private autobus operations.

The percentages set forth in the 1995 proposal do not apply to casino or regular route in the nature of special, charter and special autobus service operating within the State. Pursuant to N.J.S.A. 48:4-2.25, the Commissioner is authorized to exempt casino or regular route in the nature of special, charter and special autobus operations from the purview of the rate regulation. In accordance with said authority, the Commissioner continues to so exempt casino or regular route in the nature of special, charter and special autobus operations within the State during the calendar year of 1995, subject to the existing conditions regarding notices to the public and filings with the Department.

Social Impact

The proposed 1995 ZORF Percentage amendment will enable private autobus carriers, in most cases, to modify regular route fares as may be required without incurring administrative hearing costs, while also limiting the chance for uncontestable fare increases to adversely impact on the public. In the Department's opinion, the fare changes permitted by the proposed 1995 ZORF will not be burdensome to the public or regular route private autobus companies.

Economic Impact

The proposed 1995 Percentage amendment will afford privately owned autobus companies flexibility in regular route fare adjustment. Such carriers will not have to incur costly and time consuming petition procedures when their proposed fare adjustments are consistent with that allowed.

Regulatory Flexibility Statement

A number of the autobus carriers affected by the proposed amendment are small businesses, as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment does not place any new reporting or recordkeeping requirements on such autobus carriers. First time autobus carriers commencing operations will have to meet the reporting and recordkeeping requirements otherwise established by law for autobus carriers. The proposed amendment sets raised limits on rate modifications for which compliance with N.J.A.C. 16:53D-3.10 and 3.11 is not required.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

16:53D-1.1 General provisions

(a) Any regular route autobus carrier operating within the State which seeks to revise its rates, fares or charges in effect as of the time of the promulgation of this rule shall not be required to conform with N.J.A.C. 16:51-3.10 (Tariff filings or petitions which do not propose increases in charges to customers) or N.J.A.C. 16:51-3.11 (Tariff filings or petitions which propose increases in charges to customers) provided the increase or decrease in the rate, fare or charge, or the aggregate of increases and decreases in any single rate, fare or charge is not more than the maximum percentage increase or decrease as promulgated below upgraded to the nearest $.05.

1. The following chart sets forth the [1994] **1995** percentage maximum for increases to particular rates, fares or charges and the resultant amount as upgraded to the amount $.05:

Present Fare	% of Increase	Increase Upgraded To Nearest $.05
$1.10 or less	[4.0%] **4.3%**	$.05
$1.15-$2.20	[4.0%] **4.3%**	$.10
$2.25-$3.30	[4.0%] **4.3%**	$.15
$3.35 upward	[4.0%] **4.3%**	$.20+

2. The following chart sets forth the [1994] **1995** percentage maximum for decrease to particular rates, fares or charges and the resultant amount as upgraded to the nearest $.05:

Present Fare	% of Decrease	Decrease Upgraded To Nearest $.05
$ .50 or less	10%	$.05
$ .55-$1.00	10%	$.10
$1.05 upward	10%	$.15+

TREASURY-GENERAL

(a)

DIVISION OF PURCHASE AND PROPERTY

Purchase Bureau

Proposed Readoption: N.J.A.C. 17:12

Authorized By: James Archibald, Deputy State Treasurer.

Authority: N.J.S.A. 52:18A-30(d), 52:25, 52:34-6 et seq., 52:32-17 et seq., 52:27H-6(f), 52:34-12(d), 10:5-36(k) and (o), 52:34-13; Executive Orders No. 34(1976) and No. 189(1988).

Proposal Number: PRN 1994-461.

Submit written comments by September 14, 1994 to:

Lana Sims, Director
Division of Purchase and Property
Department of the Treasury
33 West State Street, CN 230
Trenton, New Jersey 08625-0230

The agency proposal follows:

Summary

In accordance with the "Sunset" and other provisions of Executive Order 66(1978), N.J.A.C. 17:12 is due to expire on October 13, 1994. The Department of the Treasury proposes to readopt, without amendments, N.J.A.C. 17:12 concerning the procedures for bidding for supplies and services necessary for the administration of State Government. This proposed readoption is necessary to permit the business of the State to continue without interruption.

These rules effectively set forth the various bidding and award requirements imposed on State purchasing contracts by State law. The Department of the Treasury has determined that these rules, which were amended during their last readoption, are necessary, reasonable, adequate, understandable and responsive to the purpose for which they were originally promulgated.

Although there have been no statutory changes necessitating their modification since the last readoption, the Division of Purchase and Property is currently developing technical and substantive refinements and modifications to these rules. However, these rule enhancements are not sufficiently developed at present and thus are not presented with this readoption.

A summary of the text of N.J.A.C. 17:12 follows:

N.J.A.C. 17:12-1 describes the organization of the Purchase Bureau, which has primary responsibility for State purchasing. N.J.A.C. 17:12-2 describes the bidding procedures. N.J.A.C. 17:12-3 describes the hearing procedures wherein interested bidders may protest the intent to award a proposed contract. N.J.A.C. 17:12-4 describes the agency complaints procedures, whereby State agencies may seek remedies for contract violations and contract performance problems. N.J.A.C. 17:12-5 describes cooperative purchasing and the participation in State contracts by political subdivisions and independent institutions of higher education, as well as volunteer fire departments, volunteer first aid or rescue squads, county colleges, State colleges, quasi-State agencies and independent authorities. N.J.A.C. 17:12-6 describes the procedures for suspension, debarment and disqualification of vendors for various causes.

Social Impact

The readoption of N.J.A.C. 17:12 will continue the procedures which have served to benefit the State and the general public. N.J.A.C. 17:12 implements the basic statutory purposes of N.J.S.A. 52:34-6 et seq. of getting the best possible product at the best possible price for the State as expeditiously and efficiently as possible while treating all vendors equally and fairly, and guarding against favoritism, improvidence, extravagance and corruption.

Economic Impact

The rules affected by this proposed readoption will continue to enhance the efficiency and cost effectiveness of operating State government and political subdivisions, thus resulting in a positive economic impact for the State. In providing purchasing services for the agencies of the State, the Purchase Bureau has a significant effect on State government budget and on the economy of the whole State. Most of these contracts are awarded through competitive bidding. These rules assist in the implementation of cost saving measures through the com-

petitive process and attempt to reconcile the State government's purchasing process with the State government's needs and the operation of the general economy.

Regulatory Flexibility Analysis

The proposed readoption with amendments of N.J.A.C. 17:12 affects all persons and entities that bid for contracts with the State for supplies and services. Many such bidders are small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. No reporting or recordkeeping requirements are imposed by the rules. The bidding procedure compliance requirements are necessary in order to ensure a fair, competitive system for State purchases. Aside from the bid and performance security requirements, necessary both as sound business practice and to protect the expenditure of public funds, the rules should impose no capital costs upon bidders beyond those normally incurred in the course of contracting in their respective business areas. No need for engagement of professional services in the bidding process is anticipated.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 17:12.

OTHER AGENCIES

(a)

NEW JERSEY HIGHWAY AUTHORITY

Garden State Parkway

Definitions; Transportation of Explosives and Other Dangerous Articles; Waste and Rubbish; Discharges; Damage to the Parkway Due to Discharges; and Response to a Discharge

Proposed Amendments: N.J.A.C. 19:8-1.1, 1.12, 2.1

Proposed New Rules: N.J.A.C. 19:8-2.13, 2.14, and 2.15

Authorized By: New Jersey Highway Authority, Antonette Pantaleo, Assistant Secretary.
Authority: N.J.S.A. 27:12B-5(j) and 27:12B-24.
Proposal Number: PRN 1994-454.

Submit written comments by September 14, 1994 to:
Roger E. Nutt, Executive Director
New Jersey Highway Authority
P.O. Box 5050
Woodbridge, New Jersey 07095

The agency proposal follows:

Summary

The proposed amendments are intended to set forth criteria for the transportation of hazardous materials on the Garden State Parkway, as well as to provide protection for the surrounding environment. The proposed new rules are also designed to limit the New Jersey Highway Authority's liability in the event of a discharge on or affecting Authority property.

New definitions for "discharge" and "hazardous materials" are added at N.J.A.C. 19:8-1.1. N.J.A.C. 19:8-1.12 is amended to replace "dangerous articles" with "hazardous material"; to clarify the applicable Federal and State transportation regulations; to add the transportation of Class A, B and C explosives as subject to prior written Authority approval; and to provide for Authority or State Police inspection prior to or after Parkway entry of any vehicle whose load is or is believed to represent a danger of discharging material. The proposed amendment to N.J.A.C. 19:8-2.1 specifically prohibits the disposal of waste oil and other hazardous material and/or their containers at any location or into any receptacle on the Parkway.

Proposed new rule N.J.A.C. 19:8-2.13 prohibits the discharge on the Parkway or adjacent property of any material which may cause an impact on Parkway operations, and requires specified securing of loose material carried by a vehicle which is likely to be discharged. N.J.A.C. 19:8-2.14 prohibits the discharge of material on the Parkway or adjacent property of material that may cause damage.

Discharging vehicle and property owners, operators and lessees are required to cooperate and take action to restore normal traffic conditions and remove discharges, with the failure to do so resulting in the impoundment of a discharging vehicle until penalties and costs are satisfied. The rule also provides for damages, in addition to any other penalties provided under law, of treble the amount of the Authority's costs arising out of the discharge violation. Proposed new rule N.J.A.C. 19:8-2.15 governs Authority action in response to a discharge, and what is required of the party responsible for the discharge by way of remediation.

Social Impact

These amendments increase the public's protection against exposure to harm from hazardous materials while traveling the Garden State Parkway. It will also insure that the cities and towns that abut the Parkway have a reduced risk of exposure to hazardous materials.

Economic Impact

These amendments will not result in increased costs for the patrons of the Garden State Parkway. Individuals who violate the dictates of these regulations will be subject to treble damages for any and all costs arising out of a violation, as well as the impounding of vehicles and other property to insure payment of fees and costs.

Regulatory Flexibility Analysis

The proposed amendments and new rules impose compliance requirements on the owners and operators of vehicles transporting hazardous materials, and upon the owners, operators and lessees of vehicles and property from which a discharge of material emanates onto the Parkway or adjacent property which impacts Parkway operations. As some material transporters and property owners may be small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., a regulatory flexibility analysis is required.

The proposed amendments to N.J.A.C. 19:8-1.12 clarify the current requirements relating to "dangerous articles" as applying to defined "hazardous materials," and do not impose new compliance requirements. The disposal of hazardous material or its containers at any Parkway locations or receptacle is prohibited, and the transport of Class A, B and C explosives will require prior written Authority approval. The new rules include general securing requirements, particularly for loose material likely to be discharged; prohibit the discharge of material likely to impact Parkway operations; require cooperation and action to clean-up any discharge; and impose additional damages for discharge equal to treble the Authority's resulting costs.

It is not anticipated that the hazardous material transportation requirements will impose new capital costs on small businesses, nor require their employment of professional services, as they are a reiteration of existing Federal and State requirements. The discharge requirements will impose the costs of clean-up on the discharging party, which costs will vary considerably with the nature and extent of the discharge. Such clean-up may necessitate the engagement of some type of environmental remediation or other removal professionals, again at a cost dependent on the discharge. The discharging party would also be liable for damages to the Authority of treble the Authority's cost arising out of a discharge.

As the discharge and hazardous material transportation requirements are imposed to protect the safety and health of Parkway patrons, Authority employees and the general public, no lesser requirements or exceptions are provided based upon business size.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]).

19:8-1.1 Definitions

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

...

"Discharge" means the unintentional or intentional action or omission resulting in the releasing, spilling, leaking, pumping, pouring, emitting, emptying, abandonment or dumping of a hazardous or non-hazardous material or waste into or on the land, water or air. This shall also include the disposal of containers of hazadous materials into receptacles for trash or recycling at any location on the Parkway.

...

"Hazardous material" means any material or substance that is capable of posing a risk to health, safety and property or as set

forth in N.J.A.C. 7:E1-17, N.J.A.C. 7:26-8 , 40 CFR Part 261 and 49 CFR Part 172, as amended or recodified.

...

19:8-1.12 Transportation of [explosives and other dangerous articles] **hazardous material**

(a) No vehicle loaded with [dangerous articles] **hazardous material, as defined in Part 172 of the United States Department of Transportation (49 CFR Part 172), the Department of Environmental Protection (40 CFR Part 261) and New Jersey laws and regulations N.J.A.C. 7:E1-1.7 and N.J.A.C. 7:26-8), as amended or recodified,** shall enter upon this Parkway unless such vehicle, its load and the transportation of such load in such vehicle shall in every respect comply with the **requirements of** the United States Department of Transportation regulations[, including regulations regarding forbidden articles, proper conditions] **49 CFR Parts 171 to 180 and Part 397 and the laws and regulations of New Jersey (N.J.A.C. 7:26), as amended or recodified, governing the preparation** for transportation, **construction and use of** containers, [packaging,] **packing, weighing,** marking, labeling, [description,] certification, quantity, limitations, [and] loading, and **the** placarding [or] **and** marking of the vehicle. [and shall comply with all other applicable, laws and regulations of the United States, the State of New Jersey and the departments and agencies thereof as they apply to dangerous or hazardous articles. United States Department of Transportation regulations shall refer to those safety regulations which were in effect December 31, 1968, and which are included in Parts 170-189 inclusive an Part 397 of Title 49, Code of Federal Regulations and Sections 831-835 of Title 18, Chapter 39, of the United States Code, pursuant to Section 9 of the Department of Transportation Act, 49 U.S.C. 1657, which deal with the transportation of explosives and other dangerous articles by motor carrier by highway.]

(b) The transportation or shipment of radioactive material **or devices, and the transportation of Class A, B, and C explosives, as defined in 49 CFR Part 173, as amended or recodified,** shall be subject to the prior written approval of the New Jersey Highway Authority. All applications for such approval shall be made in writing addressed to the operations [manager] **department** of the Authority and shall provide to the satisfaction of the Authority that the shipment will comply in all respects with the provisions of [part 71 to 78] **Parts 171 to 180 and 397** inclusive of the regulations [of the Interstate Commerce Commission] (49 CFR [71 to 78] **171-180 and 397**) as amended **or recodified.** [to July 24, 1963, governing the preparation of the articles for transportation, cosntruction of containers, packing, weight, marking, labeling, billing and certification of such articles, and part 197 of the Regulations of the Interstate Commerce Commission (49 CFR 197) as amended to June 2, 1953, governing drinking rules.]

(c) The Authority reserves the right, however, to refuse to grant such approval **as required in (b) above and prohibit entry to the Parkway of any hazardous material,** despite compliance with the aforementioned [Interstate Commerce Commission] regulations, if in its opinion, the transportation or shipment will be likely to unreasonably endanger life or property.

(d) [Additionally, transporation of hazardous material on the Garden State Parkway shall be in conformance with all United States and New Jersey statutes, laws and regulations as amended or modified, which are referenced in this subchapter or applicable to the transportation of hazardous materials.] **Any vehicle whose load is or is believed to represent a danger of discharging any material, by a representative of the Authority or State Police, shall be subject to an inspection prior to or at any time after entering onto the Parkway.**

19:8-2.1 Waste and rubbish

No person shall throw, drop or discard bottles, cans, paper, garbage, rubbish or other material of any kind or description on the Parkway. **No person shall dispose of waste oil and other hazardous materials and/or their containers at any location or into any receptacle on the Parkway.**

19:8-2.13 Discharges

(a) Any material being carried by a vehicle shall be firmly secured and vehicles carrying loose material likely to be discharged that is not otherwise boxed, crated, bagged or packaged, shall be firmly secured on all sides with a tarpaulin completely covering the material, and capable of preventing the escape of said material.

(b) No material shall be discharged on the Parkway or on the property adjacent to the Parkway which may cause an impact on the operations of the Parkway. This prohibition shall apply to any material being carried as cargo in or on a vehicle, by any person or by any contractor or vendor of the Authority, and to any material that is a part of the vehicle or necessary for the operation of the vehicle or any apparatus affixed thereon, but shall not apply to ordinary vehicular emissions anticipated by the original design of the vehicle.

19:8-2.14 Damage to the Parkway due to discharges

(a) No material shall be discharged on the Parkway or on the property adjacent to the Parkway, that may cause damage to the Parkway, the general public, the environment, the Authority, its agents and employees. For purposes of this section only, "damage" includes any effect which may be injurious to health, safety or welfare, cause the contamination of the environment including soils and ground water, or which may cause financial loss or delay the movement of traffic.

(b) The operator, owner or lessee of any vehicle, lessee of Authority property, or owner or lessee of adjacent property from which a discharge in violation of any provision of this section or N.J.A.C. 19:8-1.12, or 2.13 occurs, regardless of the cause of the discharge, shall cooperate fully with the Authority, its employees, agents, and third parties (authorized to respond to an emergency, discharge or blockage of traffic by the Authority), the State Police and the New Jersey Department of Environmental Protection (NJDEP) and shall take any action deemed necessary by them to restore normal traffic conditions and to remove spilled or otherwise discharged material from the Parkway immediately. The vehicle operated, owned or leased by any person, lessee of Authority property, or the owner or lessee of the adjacent property failing to cooperate or take such action as deemed necessary by the official in charge of the scene where the discharge occurred is subject to impoundment by the Authority, or its agents and their employees until such time as all penalties, towing and storage fees and costs have been satisfied.

(c) In addition to any penalties prescribed by this chapter or by the laws and regulations of other government entities including, but not limited to, Titles 2C, 13, 27, 39 and 58 of the New Jersey Statutes and Federal law or regulation, any person violating any provision of this section or N.J.A.C. 19:8-1.12, 2.13 or 2.15, shall be liable to the Authority for treble the amount of damages for any and all costs arising out of said violation, including, but not limited to, the costs of:

1. Collecting, testing and properly disposing of the material and any noted contaminated soils or ground water and providing the Authority with all copies of results and documentation of same;

2. Replacing or repairing, in the Authority's sole discretion, any property damaged by reason of said violation.

3. Toll and other revenues lost because of closing of the Parkway, any part thereof, by reason of said violation;

4. Medical care, supervision or other costs relating to personal injury suffered by the general public, the Authority, its agents or employees; and

5. Any other costs arising out of said violation and incurred by the Authority, its Consultants or third parties.

(d) The Authority may recover the costs under (c) above by way of complaint filed in a court of appropriate jurisdiction, by an administrative consent order executed by an authorized representative of the Department of Environmental Protection or by any other lawful means.

19:8-2.15 Response to a discharge

(a) Any operator, owner or lessee of a vehicle on the Parkway which contains any hazardous or non-hazardous material shall be

subject to all provisions and penalties hereunder, in addition to any provisions of the United States Code, the New Jersey Statutes and the New Jersey Administrative Code.

(b) In the event of a discharge of hazardous or non-hazardous material on the Parkway or on adjacent property impacting the Parkway, all remedial efforts shall be conducted in compliance with these rules and under the supervision of the Authority, the State Police, and/or the Department of Environmental Protection.

1. Where practicable, but not contrary to the rules of the NJDEP, and not contrary to the safety of the operator, the general public or the Authority, the operator, owner or lessee of the vehicle, lessee of Authority property or owner or lessee of adjacent property may be afforded the opportunity to contain and remove discharged material using personnel, materials and equipment:

i. Aboard the vehicle or on the property from which the discharge occurred;

ii. Aboard another vehicle owned or leased by the operator, owner or lessee of the vehicle or of the property from which the discharge occurred;

iii. By a specialized response team operated by the manufacturer or distributor of the hazardous or non-hazardous material that has been discharged; or

iv. By third parties contracted to contain, clean up, and/or dispose of the discharge (hereafter "emergency response contractors") by the operator, owner or lessee of the vehicle or of the property specifically for the purpose of remediating hazardous or non-hazardous materials discharged from the operator's, owner's, or lessee's vehicle or property.

2. No emergency response services may be provided pursuant to (b)1i through iv above unless all the entities undertaking such services have provided to the Authority proof of adequate insurance, registration with the NJDEP (as per N.J.A.C. 7:E1-4.2) and other such information as may be required by the Department of Operations.

3. The Authority shall make available to any operator, owner or lessee of a vehicle or property so requesting a list of emergency response contractors as compiled by the NJDEP. The operator, owner or lessee of a vehicle or property shall arrange and pay for emergency response services to be performed by such contractors. Approval of such contractors pursuant to (b)2 above is not to be considered a warranty or assurance by the Authority of such contractors' ability to perform emergency response services.

4. Whenever the operator, owner or lessee of a vehicle or property from which a discharge occurred refuses to arrange for an emergency response contractor, or whenever dangerous circumstances or the risk posed by the discharge to the general public, the environment or the Authority's agents or employees is too great to await the arrival of the emergency response contractor(s) arranged by the operator, owner or lessee in the opinion of the Department of Operations or its designee, the Department or its designee may arrange for emergency response services and long-term remedial efforts to be provided by a third party of the Authority's choice. Emergency response and long term remedial services may be performed by or through the NJDEP or its agents, including any county environmental health department, or by private organizations engaged by the Authority. The cost of services pursuant to this paragraph shall be based on the schedule of rates normally charged for emergency response or long-term remedial services, and shall be borne by the operator, owner or lessee of the vehicle or property from which a discharge occurred.

i. If, at the time the emergency response contractor arrives at the scene of the discharge, the operator, owner or lessee of the vehicle or property from which a discharge occurred refuses to agree to pay or complete any documents necessary to engage the contractor for such services, the Authority may impound the vehicle and any cargo or contents thereof until such time as the costs of remedial services are satisfied. If such costs are not satisfied within 14 days, the Authority shall have the right to sell the vehicle, its cargo and contents at public auction and/or to recover treble the amount of damages for any unsatisfied costs by filing a civil action in a court of appropriate jurisdiction over such action.

ii. If the emergency response contractor refuses to contract with the operator, owner or lessee of the vehicle or property from which a discharge occurred because of a bona fide concern about the operator's, owner's or lessee's ability or willingness to pay for such services, the Department or the Department's designee may authorize such services to be performed at the Authority's expense, and the Authority may thereafter recover treble the costs thereof from the operator, owner or lessee from which a discharge occurred by filing a civil action in a court of appropriate jurisdiction over such action. The emergency response contractor's concern shall be deemed bona fide if the operator's, owner's or lessee's credit record indicates a history of refusal or failure to pay commercial debts.

5. Access to Authority property for the purposes of investigating or remediating contamination caused by the discharge or release of any material will be granted only after compliance with (b)2 above and only after notification to the Chief Engineer of the Authority. Such access will not be unreasonably withheld. All investigatory data, including but not limited to, soil investigations, soil boring logs, ground water monitoring well logs, laboratory analytical data, correspondence with regulatory agencies, and all reports and submissions generated as a result of work on Authority property shall be made available for inspection by the Authority or its agents, and copies of all such information and data shall be produced for the Authority or its agents upon request.

(a)

NEW JERSEY HIGHWAY AUTHORITY

Garden State Parkway

Parking, Standing or Stopping on Parkway Prohibited Except in Emergency

Proposed Amendment: N.J.A.C. 19:8-1.8

Authorized By: New Jersey Highway Authority, Antonette Pantaleo, Assistant Secretary.
Authority: N.J.S.A. 27:12B-5(j) and 27:12B-24.
Proposal Number: PRN 1994-456.

Submit written comments by September 14, 1994 to:
Roger E. Nutt, Executive Director
New Jersey Highway Authority
P.O. Box 5050
Woodbridge, New Jersey 07095

The agency proposal follows:

Summary

The proposed amendment at N.J.A.C. 19:8-1.8 is intended to redefine the instances when parking, stopping or standing are prohibited on the Garden State Parkway to include weather conditions that obstruct travel. The proposed amendment also further defines what is considered an emergency on the Garden State Parkway that will allow the Authority or the State Police to remove any vehicle determined to be obstructing traffic or which constitutes an unsafe condition.

Social Impact

The proposed amendment is intended to have no social impact upon Parkway patrons, other than to ensure the safe and efficient use of the highway by the motoring public.

Economic Impact

The proposed amendment may result in increased costs for the patrons of the Garden State Parkway. Individuals who violate the dictates of these rules will be subject to all costs arising out of a violation, as well as the cost of towing as set forth in N.J.A.C. 19:8-2.12, Emergency Service.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendments do not impose reporting, recordkeeping or other compliance requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The sole effect of the amendment is to redefine when parking, stopping or standing is prohibited on the Garden State Parkway and to define the term "emergency" as it relates to the foregoing.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]).

19:8-1.8 Parking, standing or stopping on Parkway prohibited except in emergency

(a) No parking, standing or stopping is permitted on the Parkway, **including during weather conditions that obstruct travel,** except in areas designated by the Authority or in cases of emergency.

(b) (No change.)

(c) For the purposes of this regulation, an "emergency" is defined as [existing only when and so long as the vehicle in question is physically inoperable, or] **the existence of inclement weather conditions that obstruct travel on the Parkway, including, but not limited to, snow, ice, flooding or high wind conditions; mechanically disabled vehicles;** the driver of the vehicle is ill or fatigued; **or conditions deemed an "emergency" by the Authority or the State Police;** but in no case shall the parking, standing or stopping exceed a two-hour period. **In any event, the Authority or the State Police may have the vehicle removed if it is determined that it is obstructing traffic or constitutes an unsafe condition.**

(d)-(h) (No change.)

(a)

NEW JERSEY HIGHWAY AUTHORITY
Garden State Parkway
Fee Policy for Construction and Utility Installation Permits
Proposed New Rules: N.J.A.C. 19:8-13

Authorized By: New Jersey Highway Authority, Antonette Pantaleo, Assistant Secretary.
Authority: N.J.S.A. 27:12B-5(j) and 27:12B-24.
Proposal Number: PRN 1994-455.

Submit written comments by September 14, 1994 to:
Roger E. Nutt, Executive Director
New Jersey Highway Authority
P.O. Box 5050
Woodbridge, New Jersey 07095

The agency proposal follows:

Summary

The proposed new rules provide for the charging of fees for construction permits and utility installation permits. The fees are intended to compensate the Authority for the resources expended in the review, inspection and administration of these permits. The permits are issued to applicants who are not contractors performing work for the Authority within its right of way. The new rules describe the services provided permit applicants by Authority staff; establish application, permit and specialized fees; regulate unauthorized installations; and provide for fee waivers.

Social Impact

These proposed new rules should have no social impact upon either patrons of the Garden State Parkway or citizens of abutting communities. The only anticipated impact is economic, as described below.

Economic Impact

These proposed new rules will not result in increased costs for the patrons of the Garden State Parkway. Applicants for construction and utility installation permits and permittees will be required to pay the proposed fees. The rules will provide for compensation to the Authority for resources expended in the administration of permits for work to be performed within the Authority's right-of-way by applicants.

Regulatory Flexibility Analysis

The proposed new rules impose compliance requirements on those seeking to perform construction and utility work within the Authority's right of way. Small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., seeking to perform such work will be required to apply for a permit. An application fee and, if the application is granted, a permit fee is imposed. Specialized fees for certain types of work are also imposed. Preparation of the application documents may require employing professional services (such as draftsmen or engineers) at varying costs; however, such services would be needed for the contemplated work in any event. Because neither the need for the Authority to regulate activity on its right of way not the difficulty of application review are directly related to the applicant's business size, no lesser requirements exemptions are provided for small businesses.

Full text of the proposed new rules follows:

SUBCHAPTER 13. FEE POLICY FOR CONSTRUCTION AND UTILITY INSTALLATION PERMITS

19:8-13.1 Purpose and objective; services provided

(a) The purpose of these rules is to establish and prescribe uniform general rules and procedures to be followed by the New Jersey Highway Authority staff in reviewing permits for applicants desiring to perform work within the Parkway right-of-way.

(b) The objective of these rules is to enable the New Jersey Highway Authority to accomplish its review, inspection and administration of permits equitably and expeditiously.

(c) To accomplish the purpose and objective of these rules, the following services for permit applicants desiring to perform work within the Parkway right-of-way will be provided:

1. Review of the conceptual work plan and offer guidance as to the type of application required and procedure to be followed;
2. Review of detailed plans and other work related documents and provide comments that best serve the Authority's interest. If required, field investigations are performed;
3. Review and approval of contractor's insurance certificate, performance bond and maintenance bond;
4. Provide direction with lane closures and overall traffic control;
5. Periodical inspection of the ongoing work to assure compliance with the approval permit; and
6. Initiation and maintainence of all permit documentation and, upon completion of work, administration of permit close-out documentation.

19:8-13.2 Fee schedule

(a) Resolution 1953-129 adopted on October 29, 1953, and amended on April 8, 1954, authorizes the Chief Engineer to fix and determine the Authority's necessary inspection and other costs in conjunction with the issuance of utility crossing permits in addition to requests from utility companies, outside agencies and developers who submit requests to perform work on Authority property that require issuance of a construction permit which requires similar staff efforts as described in N.J.A.C. 19:8-13.1(c).

(b) The following fee schedule is established to offset the costs of review, administration, inspection and other necessary tasks performed by Authority staff for all Construction and Utility Installation Permits. The final decision concerning the basis and amount of fees shall be solely the responsibility of the Authority's Chief Engineer. The fee schedule will be established as follows:

1. Application Fee: A $250.00 fee to be submitted along with the completed permit application and associated documents. Such fee shall be non-refundable whether the Authority's final decision is to issue or deny the requested permit.
2. Permit Fee: A non-refundable fee consisting of five percent of the total cost of construction to be performed on Authority property or $500.00, whichever is greater, plus any additional specialized fee as described in (b)3 below. As a permit requirement, the applicant shall submit an Engineer's Estimate of the work to be performed on Authority property. Such estimate shall be based on current prevailing construction rates for all work items. The Chief Engineer reserves the right to reject any estimate that is determined to be non-conformance with standard construction rates or not in the best interest of the Authority. Such permit fee shall be paid prior to issuance of the permit.
3. Specialized Fees:

i. Work performed by the contractor involving lane/shoulder closures or slow downs shall require the following non-refundable administrative fees:

(1) Shoulder Closure ... $250.00 per location per day;
(2) Lane Closure ... $500.00 per lane per location per day; and
(3) Slow downs ... $750.00 per set up

ii. Fees for all other items of specialized work shall be determined by the Chief Engineer on a case-by-case basis. Such determination shall be based upon the amount of staff time and services utilized. Documentation of these costs shall be provided upon request. Such specialized fees, even though determined separately, will be considered and collected as part of the permit fee.

19:8-13.3 Unauthorized installations

Anyone performing work within Authority property without the required permit will be ordered to stop work immediately. The Authority will inspect all work performed on Authority property and make a recommendation for removal, restoration, remediation and/or submission of required permit application and associated fees. Any person or persons performing unauthorized work on Authority property will be charged a $1,000 fee for performing unauthorized work and will be required to submit an application for the appropriate permit to remove, restore, remediate and/or continue construction work as approved by the Chief Engineer. All associated fees as outlined in N.J.A.C. 19:8-13.2 will also apply. All fees are non-refundable.

19:8-13.4 Waiver

The Chief Engineer may waive the fees, or some portion thereof, upon written request for a waiver from the applicant submitted at the time of application, based upon the Chief Engineer's determination that the fee is not warranted. Said determination shall be based upon the nature of the entity making the request, that is, a Federal, State or local government agency, and the nature of the project for which the permit is requested.

(a)

CASINO CONTROL COMMISSION

Notice of Administrative Correction
Accounting and Internal Controls
Gaming Equipment
Slot Tokens
Prize Tokens
Slot Machine Hoppers
Reproposed New Rules: N.J.A.C. 19:46-1.34 through 1.36
Reproposed Amendments: N.J.A.C. 19:40-1.2; 19:45-1.1, 1.9, 1.9B, 1.14, 1.15, 1.24, 1.24B, 1.25A, 1.34, 1.35, 1.36, 1.36A, 1.37, 1.38, 1.39, 1.40, 1.40A, 1.40C, 1.41, 1.43, 1.44, 1.46 and 1.46A; 19:46-1.5, 1.6, 1.26 and 1.33; 19:51-1.1 and 1.2
Proposed Amendments: N.J.A.C. 19:45-1.46B; 19:46-1.20; and 19:54-1.6

Take notice that the Casino Control Commission has discovered a typographic error in the text of the Summary in the above-referenced notice of proposal, published in the July 18, 1994 New Jersey Register at 26 N.J.R. 2872(a). The word "not" is omitted from the second clause of the second sentence of the Summary's 16th paragraph (see PRN 1994-409). The sentence should read as follows: "Although it is anticipated that slot machines that dispense prize tokens will have one all-purpose hopper and one payout-only hopper, the reproposal would not preclude slot machines from having two payout-only hoppers." This notice is published pursuant to N.J.A.C. 1:30-2.7.

ENVIRONMENTAL PROTECTION

(b)

NEW JERSEY HISTORIC TRUST
Historic Preservation Bond Program
Proposed Amendments: N.J.A.C. 7:4A-2.3 and 7:4B-3.1
Proposed New Rules: N.J.A.C. 7:4C

Authorized By: New Jersey Historic Trust, Arijit De, Chairman.
Authority: N.J.S.A. 13:1B-15.111 et seq. and P.L. 1992, c.88.
DEP/Docket Number: 36-94-07.
Proposal Number: PRN 1994-467.

Submit written comments by September 14, 1994 to:

Department of Environmental Protection
Attn: Janis Hoagland
Office of Regulatory Affairs
401 East State Street
Trenton, New Jersey 08625
and
Harriette Hawkins
Executive Director
New Jersey Historic Trust
CN 404
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The New Jersey Historic Trust, a body corporate and politic in the DEP, is a nonprofit historic preservation organization created to preserve and protect New Jersey's historic resources. The Trust is governed by an 11-member board of trustees. Eight members are private citizens appointed by the Governor, with the advice and consent of the Senate. Three members serve ex-officio, representing the State Treasurer, the New Jersey Historical Commission and the Commissioner of the Department of Environmental Protection.

The Trust is proposing new rules at N.J.A.C. 7:4C to implement its Historic Preservation Bond Program. On a competitive basis, grants will be awarded for historic preservation projects for the improvement, restoration, stabilization or rehabilitation of historic properties owned by State, county and municipal governments and by tax-exempt nonprofit organizations in accordance with the "New Jersey Green Acres, Clean Water, Farmland and Historic Preservation Bond Act of 1992," P.L. 1992, c.88. This is the second Bond Act program to be administered by the Trust; its requirements vary from the requirements of the Bond Act of 1987 and its governing regulations set forth at N.J.A.C. 7:4A. The 1992 Act allows for greater flexibility in determining eligible activities and the rate of funding by the Trust.

The proposed rules set forth at N.J.A.C. 7:4C establish the procedures to be followed when applying for a historic preservation grant, historic preservation activities eligible for funding, criteria for the selection of projects to be funded and requirements for work funded under this program.

The proposed rules provide as follows:

N.J.A.C. 7:4C-1 sets forth the purpose of the chapter and defines certain terms used in the rules.

N.J.A.C. 7:4C-2 establishes the applicants, property and activities eligible for funding under the Historic Preservation Bond Program. This subchapter also establishes grant application procedures.

N.J.A.C. 7:4C-3 provides that grant funds are to be allocated in accordance with a ranking of applications received and sets forth the criteria for the ranking of applications.

N.J.A.C. 7:4C-4 provides that to assure the continued preservation of grant-assisted historic properties and to assure that public benefit will continue from the use of public funds after expenditure of the grant monies, the Trust cannot make grant assistance available until an agreement conveying an easement on the grant-assisted historic property is executed between the Trust and the grant recipient and all other parties with interests in the property.

N.J.A.C. 7:4C-5 provides that a project sign is to be prominently located and maintained on the project site acknowledging that the historic preservation project is being funded with grant assistance through the New Jersey Historic Preservation Bond Program.

N.J.A.C. 7:4C-6 provides for a schedule of fees to be charged to defray the costs of monitoring easements.

The New Jersey Historic Trust proposes to amend its rules for the operation of its Historic Preservation Grant Program to list categories of items not eligible for funding under its grants as administrative, personnel or indirect costs. This modification will make the rules for this program consistent with the new rules proposed here by the Trust to govern its Historic Preservation Bond Program. Proposed N.J.A.C. 7:4A-2.3(b)3 sets forth eight categories of administrative and/or operational costs which are not eligible for funding.

The procedures for applying for a Historic Preservation Loan pursuant to N.J.A.C. 7:4B are being modified to allow applicants the option of paying for the delivery of a credit report directly to the Trust or advancing the cost to the Trust and having the loan application deemed complete upon submission. N.J.A.C. 7:4B-3.1(c)12 sets forth the applicant's option of paying for direct delivery to the Trust of an up-to-date credit report from an independent credit reporting agency or providing a check for $100.00 to the Trust to cover the expense of obtaining the necessary report.

Social Impact

The proposed new rules will have a positive social impact by establishing procedures for making grants and loans available for the restoration, preservation or rehabilitation of historic properties owned by the State, county and municipal governments and by tax-exempt nonprofit organizations. Funding from these programs will assist in the preservation of historic heritage which otherwise would be lost; will help stabilize neighborhoods; and will help retain the historical elements which establish the unique identity of our communities.

The amendment to N.J.A.C. 7:4A-2.3(b)3 will assist grantees in planning projects by providing additional examples of ineligible activities. The amendment to N.J.A.C. 7:4B-3.1(c) will also have a positive impact by providing the Trust with information critical to lending decisions while allowing grantees the option of providing it by a choice of methods.

Economic Impact

The proposed new rules will facilitate the distribution of funds for and provide the means by which funds are made available for historic preservation projects. The historic properties assisted with funds provided under the Historic Preservation Bond Program, Historic Preservation Grant Program, and the Revolving Loan Program, will play an important part in stimulating and sustaining local revitalization and stabilization efforts, and will generate jobs for the design and building trades. An increase in community tax ratable property may result from the grant funding. The improvement in historic sites will also assist in the development of historic tourism. The administrative costs of application will be borne by the applicants.

The easement monitoring program will have a positive impact as it will allow grantees to provide financial support for the continued preservation of the property through meaningful review of preservation easements and assures that a sum certain will be included in each grant for this purpose. The credit report required for a complete, loan application will provide critical information to the Trusts loan making decisions. Grantees may provide the report directly or advance a sum certain to cover the cost of ordering this from an independent credit reporting agency. Grantees may choose whatever method is cost effective and most convenient to the organization.

Environmental Impact

The proposed new rules will have a positive environmental effect because they will provide funds for the efficient reuse and conservation of New Jersey's older buildings. The Historic Preservation Grant Program will help conserve open space, historic viewsheds, and cultural landscapes. Further, it will serve as a catalyst for the revitalization of many of the State's older neighborhoods.

Regulatory Flexibility Analysis

The purpose of the proposed new rules is to provide a procedure by which grants are given to State, county and municipal governments and tax-exempt nonprofit organizations for historic preservation projects. Some of the nonprofit organizations may be considered small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The administrative costs of applying for, and complying with, the conditions of the grant are minimized by the following: Trust staff is available for technical assistance in the application process; documentation required by the Trust is a routine component of budgeting for and managing capital improvement activities; and all requirements are clearly explained prior to commencement of the project, thereby reducing unnecessary work. The cost of completing a grant request, including the need to retain outside professional services, will vary depending upon the expertise of the grantee and the complexity and scope of the proposed project. No new costs will be associated with the clarification of the grant program rules at N.J.A.C. 7:4A-2.3(b)3. The amendments to N.J.A.C. 7:4B-3.1(c) do impose a cost of up to $100.00 for each loan application will be incurred by entities seeking loans from the Trust to cover necessary credit reports. This cost will only be incurred by those seeking these low interest funds and applicants have the option of methods of meeting this requirement which will assist smaller organizations by providing additional flexibility. Some costs of application may be reimbursed to grantees.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:4A-2.3 Historic preservation activities eligible for funding

(a) (No change.)

(b) Costs incurred in the following activities are not eligible for funding by the historic preservation grant program:

1.-2. (No change.)

3. [Personnel or administrative overhead or any other indirect cost;] **Administrative or operational costs of the agency receiving funding except as specified in N.J.A.C. 7:4C-2.3(a)7. Administrative costs shall include:**

i. Salary and payroll expenses including full-time, part-time, and temporary workers;

ii. Leasing or rental expense;

iii. Office supplies or equipment;

iv. Insurance;

v. Utilities;

vi. Travel;

vii. General maintenance; or

viii. Miscellaneous.

4.-23. (No change.)

7:4B-3.1 Procedures

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

(c) The applicant shall include this following information in the application:

1.-10. (No change.)

11. A resolution of the governing body of the applying county or municipality, or a resolution of the board of directors of the applying nonprofit organization, recommending the historic preservation project for funding under the Program; [and]

12. All applicants shall:

i. Purchase and arrange for delivery to the trust directly from a recognized, independent credit reporting agency an up-to-date credit report for the entity seeking the loan; or

ii. Submit a check for $100.00 to the Trust to cover the expense of any reports. Any application submitted under (c)12i above shall be deemed complete only when the report is received by the Trust directly from the reporting agency; and

[12.]**13.** (No change in text.)

(d)-(f) (No change.)

CHAPTER 4C
HISTORIC PRESERVATION BOND PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

7:4C-1.1 Purpose

This chapter constitutes the rules of the New Jersey Historic Trust in the Department of Environmental Protection for the Historic Preservation Bond Program for the award of grants on a competitive basis for the restoration, restoration or rehabilitation of historic properties owned by State, county and municipal government agencies or entities and by tax-exempt nonprofit organizations in accord with the "New Jersey Green Acres, Clean Water, Farmland and Historic Preservation Bond Act of 1992," P.L. 1992, c.88.

7:4C-1.2 Severability

If any portion of this chapter is declared invalid by a court of competent jurisdiction, the remainder of this chapter is not to be affected.

7:4C-1.3 Definitions

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

"Act" means the "New Jersey Green Acres, Clean Water, Farmland, and Historic Preservation Bond Act of 1992," P.L. 1992, c.88.

"Applicant" means the State, county and municipal government entity or agency, or nonprofit organization that submits an application for an historic preservation grant.

"Approved project period" means the amount of time prescribed in the "project agreement" during which the grant recipient must complete satisfactorily the approved historic preservation project to be eligible for the full funding authorized for the project.

"Deputy State Historic Preservation Officer" means the Administrator, Historic Preservation Office, Department of Environmental Protection, designated by the Commissioner of the Department of Environmental Protection to administer the State Historic Preservation Program to identify and nominate eligible properties to the National Register of Historic Places.

"Grant recipient" means the applying State government agency, county or municipal government entity or agency, or nonprofit organization names in a project agreement executed with the Trust which has been selected to receive grant funds for a historic preservation project.

"Historic" as applied to any property, structure, facility or site means any area, site, structure or object approved for listing or which has been certified as meeting the criteria for listing in the New Jersey Register of Historic Places as set forth at N.J.A.C. 7:4.

"Historic preservation grant" means monies approved by the New Jersey Historic Trust to fund an historic preservation project.

"Historic preservation project" means work directly related to the restoration, preservation or rehabilitation of an historic property, structure, facility or site.

"National Register of Historic Places" means the national list of districts, sites, buildings, structures and objects significant in American history, architecture, archaeology, engineering or culture maintained by the Secretary of the United States Department of the Interior under authority of the National Historic Preservation Act, as amended (16 U.S.C. §§470 et seq.)

"Nonprofit organization" means a corporation organized under the New Jersey Nonprofit Corporation Act, N.J.S.A. 15A:1-1 et seq. and qualified for tax-exempt status under the Internal Revenue Code of 1986 (26 U.S.C. §501(c)).

"Preservation" means the act or process of applying measures necessary to sustain the existing form, integrity, and material of an historic property.

"Project agreement" means a document executed by the New Jersey Historic Trust and a grant recipient which provides a specified amount of grant assistance for an historic preservation project approved by the Trust and subject to conditions to assure benefit to the public and continued preservation of the property, structure or site.

"Property" means the historic site, structure or facility which is the subject of the historic preservation project.

"Reconstruction" means the act or process of depicting, by means of new construction, the form, features, and detailing of a non-surviving site, landscape, building, structure, or object for the purpose of replicating its appearance at a specified period of time and in its historic location.

"Rehabilitation" means the act or process of making possible a compatible use for a property through repair, alterations, and additions while preserving those portions or features which convey its historical, cultural or architectural values.

"Restoration" means the act or process of accurately depicting the form, features, and character of a property as it appeared at a particular period of time by means of the removal of features from other periods in its history and reconstruction of missing features from the restoration period.

"Secretary of the Interior's Standards" means the Standards for the Treatment of Historic Properties (Revised 1992) adopted by the Secretary of the United States Department of the Interior, as from time to time modified, changed or amended, incorporated herein by reference.

"Site" means the location of a significant event, a prehistoric or historic occupation or activity, or a building or structure whether standing, ruined or vanished where the location itself maintains historic or archaeological value regardless of the value of any existing structure.

"State Historic Preservation Officer" means the Commissioner of the Department of Environmental Protection designated by the Governor to administer the State Historic Preservation Program to identify and nominate eligible properties to the National Register of Historic Places. The State Historic Preservation Officer establishes the procedures and criteria under N.J.A.C. 7:4 for receiving and processing nominations and approving areas, sites, structures and objects, both publicly and privately owned, for listing in the State Register of Historic Places.

"State Register of Historic Places" means the New Jersey Register of Historic Places consisting of areas, sites, structures and objects significant in American history, architecture, archaeology and culture which the Commissioner of the Department of Environmental Protection is authorized to maintain and expand under the "New Jersey Register of Historic Places Act," N.J.S.A. 13:1B-15.128 et seq.

"State Review Board" means a body whose members represent the professional fields of American history, architectural history, prehistoric and historic archaeology, and other professional disciplines appointed by the State Historic Preservation Officer as part of the State Historic Preservation Program for the purpose of reviewing and recommending to the State Historic Preservation Officer whether to approve New Jersey and National Register nominations based on whether or not they meet the criteria for evaluation in N.J.A.C. 7:4-2.3.

"Structure" means a work constructed by humans and made up of interdependent and interrelated parts in a definite pattern or organization.

"Trust" means the New Jersey Historic Trust, a body corporate and politic with corporate successor established in the Department of Environmental Protection under N.J.S.A. 13:1B-15.111 et seq.

SUBCHAPTER 2. APPLICATION PROCEDURE AND ELIGIBILITY FOR HISTORIC PRESERVATION GRANTS

7:4C-2.1 Eligible applicants

State, county, and municipal government agencies or entities, and tax-exempt nonprofit organizations that own or lease on a long-term basis a historic structure, facility, or property, are eligible to submit applications for historic preservation grants.

7:4C-2.2 Eligible property

(a) At the time of the Trust's receipt of the application, the specific property for which the application is submitted must be:

1. Owned in fee simple by the applicant; or

2. If the property is not owned in fee simple by the applicant, the applicant must have possession and sufficient control over the property under a long-term lease to guarantee the continuing preservation, on-going maintenance and public access requirements for the historic property under this chapter. No historic preservation project proposed for leased property shall be approved for funding unless:

i. The lease cannot be revoked at will by the lessor;

ii. The unexpired term of the lease is 20 years or more as of January 1, 1993; and

iii. The application for the historic preservation grant is endorsed by all owners, lessors, and lessees, of the leased premises as the case may be; and

3. The property is:

i. Listed individually in the National or State Register of Historic Places as set forth in N.J.A.C. 7:4;

ii. Located within an historic district listed in the National or State Register of Historic Places and identified in the nomination of the district as contributing to its significance; or

iii. The State Historic Preservation Officer certifies that the property, structure, facility or site is approved for listing or meets the criteria for listing in the State Register of Historic Places as set forth in N.J.A.C. 7:4.

7:4C-2.3 Activities eligible for funding

(a) The following activities are eligible for funding by the program:

1. Preservation;

2. Rehabilitation;

3. Restoration;

4. Non-construction activities related directly to the development, implementation, operation and monitoring of historic preservation projects may be funded in an amount not to exceed 25 percent of the total approved historic preservation grant. Non-construction activities eligible for reimbursement are:

i. Architectural plans, designs, specifications, cost estimates, reports and other contract documents;

ii. Feasibility studies;

iii. Historic structure reports;

iv. Historic landscape reports;

v. Archaeological investigation and reports;

vi. Engineering reports;

vii. Historic research reports;

viii. Project completion reports;

5. Project signs, required under N.J.A.C. 7:4C-5;

6. Interpretive signs, plaques, or literature approved or required by the Trust for funding as part of an historic preservation grant; and

7. Expenses for materials or professional services incurred in the preparation of a grant application by nonprofits which receive grants of $50,000 or less through this program. Reimbursable costs for this activity may not exceed $1,000 and are subject to the limits for non-construction costs as specified in N.J.A.C. 7:4C-2.3(a)4.

(b) Costs incurred in the following activities are not eligible for funding by the historic preservation grant program:

1. Acquisition of real or personal property;

2. Reconstruction;

3. Administrative or operational costs of the agency receiving funding except as specified in (a)7 above. Administrative costs shall include:

i. Salary and payroll expenses including full-time, part-time and temporary workers;

ii. Leasing or rental expenses;

iii. Office supplies or equipment;

iv. Insurance;

v. Utilities;

vi. Travel;

vii. General maintenance; or

viii. Miscellaneous;

4. Ceremonial expenses;

5. Expenses for publicity, with the exception of the required project sign, and interpretive expenses stipulated by the grant agreement;

6. Bonus payments of any kind;

7. Charges for contingency reserves;

8. Charges in excess of the lowest bid, when competitive bidding is required by the State or the recipient, unless the Trust agrees in advance to the higher cost;

9. Charges for deficits or overdrafts;

10. Interest expense;

11. Damage judgements arising from construction, or equipping a facility, whether determined by judicial process, arbitration, negotiation, or otherwise;

12. Services, materials, or equipment obtained by a local or county entity or agency or nonprofit under any other State program;

13. Costs of discounts not taken;

14. Contract cost overruns, not approved, which exceed the allowable amount under contract specifications;

15. Fund raising including grant application expenses, except as noted in (a)7 above;

16. Lobbying;

17. Work including construction, research, and preparation of plans and reports performed outside the approved project period;

18. Work including construction, research and preparation of plans and reports not included in the scope of work set forth in the project agreement;

19. Work which does not comply with the Secretary of the Interior's Standards;

20. Work performed for the State, a county or a municipal government which has not been awarded in compliance with the State Contracts Law, N.J.S.A. 52:32-1 et seq. or the Local Public Contracts Law, N.J.S.A. 40A:11-1 et seq.

21. Work performed for a nonprofit corporation which has not been awarded in compliance with bidding requirements if the aggregate cost of contract for the historic preservation project funded with a historic preservation grant exceeds $50,000;

22. Routine maintenance work; or

23. Relocation of structures, buildings or objects except that this activity may be eligible for an historic preservation grant if the following conditions are met:

i. Relocation of the structure, building or object is necessary for its preservation;

ii. The relocation re-establishes the historic orientation, the immediate setting, and general environment of the property; and

iii. The State Historic Preservation Officer determines that the property, as relocated, will continue to meet the criteria for listing in the State Register.

7:4C-2.4 Procedures

(a) Announcement of grant rounds and the opening and closing dates for submission of historic preservation grant applications shall be published by the Trust in the DEP Bulletin, major daily papers, and periodicals circulated to the historical and preservation community.

(b) The following three basic steps constitute the historic preservation grant application procedure:

1. The applicant must submit a separate written application for each historic preservation project.

2. A notice of receipt for each application will be sent by the Trust to each applicant.

3. If the application is approved and funds are appropriated by law, funds are to be distributed in accord with a project agreement between the Trust and the applicant which specifies, among other things:

i. Amount of grant;

ii. Project period;

iii. Project scope; and

iv. Special requirements.

(c) Each project application must contain sufficient information to ensure that the Trust is able to conduct an adequate and thorough review. Applications shall be on forms provided by the Trust and must contain at least:

1. A statement of the significance and condition of the property;

2. A description and justification for the proposed project;

3. Cost estimates for proposed work;

4. Photographic documentation;

5. Evidence of matching funds commitment as specified at N.J.A.C. 7:4C-2.5;

6. Long-range plans for the future use and preservation of the property;

7. The names and addresses of all owners, all parties with an ownership interest, and evidence of ownership or an interest in ownership of the historic property for which a grant is requested;

8. As applicable, the names of lessors and lessees, and a copy of a long-term lease meeting the requirements of N.J.A.C. 7:4C-2.2(a)2;

9. If the property for which a grant is requested is not listed in the State or National Register of Historic Places, a certification by the State Historic Preservation Officer that, as of the date of the Trust's receipt of the application, the historic property for which a grant is requested is approved for listing or meets the criteria for listing in the State Register of Historic Places as set forth in N.J.A.C. 7:4; and

10. A copy of a resolution of the governing body of the applying county or municipal government agency or entity; or a resolution of the board of directors of the applying nonprofit organization; or the signature of the head of the applying State agency recommending the historic preservation project for funding under the Historic Preservation Grant Program.

(d) Applications not funded in a given grant round shall not receive further consideration for funding by the Trust in that grant round; however, revised or new applications can be submitted in subsequent grant rounds.

(e) Application materials for projects not funded are to be retained by the Trust for 90 days following the announcement of grant awards, and are to be returned if an applicant submits a written request to the Trust within the 90 day period. After 90 days the Trust may discard all application materials for nonfunded projects.

7:4C-2.5 Matching funds

(a) To be eligible for a grant for a historic preservation project, the applying State, county or municipal government entity or agency shall, as part of the application for a historic preservation grant, demonstrate the ability to match the grant requested by generating $1.00 in funds for every $1.00 of grant money requested in the application.

(b) Tax-exempt, nonprofit organizations awarded grants up to $100,000 are eligible for a 3:2 funding match in which the Trust may provide up to 60 percent of project funding while the grant recipient is responsible for generating a minimum of 40 percent of project funding.

(c) Funds derived from the sale of debt of the State of New Jersey or special appropriations by the State Legislature shall not be used as the matching share of projects costs by tax-exempt nonprofit organizations or county or municipal government entities or agencies.

(d) Funds raised by the applicant up to two years prior to August 20, 1992, as well as after that date, for ongoing historic preservations projects, and of which the project described in the application is a significant and substantial part, may satisfy the matching funds requirement enumerated in (a) above if:

1. As part of the application, the applicant submits evidence of payment, plans and specifications or other items documenting the expenditure of funds by the applicant and describing the work performed; and

2. The Trust determines that the work performed is part of the historic preservation project described in the application and the work was performed in accordance with the Secretary of the Interior's Standards.

(e) An applicant matching share shall consist only of cash raised by the applicant except as provided in (c) above or funds spent by applicant on an on-going historic preservation project as provided in (d) above. If matching funds have not been spent or are not in hand at the time of application, applicants must describe in detail plans for procuring matching funds.

SUBCHAPTER 3. ALLOCATION OF HISTORIC PRESERVATION GRANT FUNDS

7:4C-3.1 Allocation of historic preservation grant funds

(a) In each round historic preservation grant funds are to be allocated in accord with a ranking of applications received by the Trust in a given grant round, subject to availability and appropriation of funds under the Act. The ranking of applications is to be established by the Trust based on criteria set forth in N.J.A.C. 7:4C-3.2.

(b) The Trust reserves the right to limit funding to less than that requested in application.

(c) Not more than 25 percent of monies made available for historic preservation projects under this act is to be awarded to State agencies or entities.

(d) Not more than 10 percent of monies may be awarded by the New Jersey Historic Trust to be utilized for historic preservation projects or programs that aid designated districts, municipalities, or geographic areas, including, but not limited to, certified local governments and Main Street New Jersey communities.

7:4C-3.2 Criteria for review and ranking of applications for historic preservation grants

(a) To determine priority for funding, all applications for eligible historic preservation projects in a given grant round are to be ranked on the basis of the following competitive criteria:

1. Significance of resource which shall involve consideration of the following:

i. The degree to which a property is historically, archaeologically, architecturally, or culturally significant in the State, according to the evaluation criteria for the National Register of Historic Places;

2. The physical condition of property, including any immediate threat of collapse, demolition or inappropriate use or development; notice of code violations; and deterioration requiring stabilization;

3. The overall quality of the work proposed for funding based on the following:

i. The quality of preliminary planning or contracts documents submitted, including degree to which documents comply with the Secretary of the Interior's Standards;

ii. The credentials and experience of project team; and

iii. A realistic and feasible budget and schedule for work proposed for funding;

4. The availability of funds to match the requested grant;

5. The ability of applicant to carry out the proposed work, develop programs to sustain and interpret the property, and provide for the long-term protection of the property;

6. The impact of the project based on the following:

i. The ability of the project to create jobs or training opportunities;

ii. The potential of the project to promote other preservation activity;

iii. The relationship of the proposed project to other State, county, municipal, or organizational planning initiatives or programs which will aid community revitalization, or protect and preserve the built or natural environment, or improve or promote heritage education; and

iv. The proposed use and interpretive program for site;

7. The financial plans for the continued preservation of the historic structure after the expenditure of historic preservation grant money;

8. The degree to which the proposed project represents innovative design or programming for a historic site and the degree to which the project reaches new audiences; and

9. The distribution of funds to achieve a geographical balance as well as a balance between sizes and types of projects, diversity of audiences served by projects, and diversity of historical or cultural periods.

7:4C-3.3 Grant payment

(a) After funds have been appropriated and the project agreement has been fully executed, subject to its approval of documents submitted pursuant to (b) below, the Trust will reimburse the grant recipient for expenditures incurred by the recipient for historic preservation activities which are eligible for funding under N.J.A.C. 7:4C-2.3 and within the scope of the historic preservation project described in the project agreement. Total reimbursements cannot exceed the amount of the grant.

(b) Reimbursement is to be made under (a) above based on itemized invoices and canceled checks approved by the Trust and referenced to completed tasks within the scope of the historic preservation project described in the project agreement. The Grant recipient must submit itemized invoices to the Trust for approval

prior to reimbursement. Invoices must itemize cost of labor and materials and describe the work performed for which reimbursement is requested. Invoices are to be submitted for each billing period set forth in the project agreement and shall be accompanied by any other documentation defined in the project agreement.

(c) Five percent of the total amount of each grant is to be retained by the Trust. The Trust is to deduct as retainage an amount equal to five percent of each payment approved under (b) above. The retainage is to be kept by the Trust until the historic preservation project has been completed and met all financial and project requirements, including submission of required reports.

7:4C-3.4 Grant amount

The minimum grant awarded for a historic preservation project shall be $20,000; the maximum amount of grant funds that may be allocated to any one historic property, structure or site is $1,250,000.

SUBCHAPTER 4. EASEMENT

7:4C-4.1 Easement on the historic property

(a) To assure the continued preservation of grant-assisted historic properties and to assure that public benefit continues from the use of public funds after the expenditure of the grant moneys, the Trust will not make grant assistance available until an easement agreement between the Trust and the grant recipient and all other parties having an ownership interest in the historic property is recorded. The easement agreement must include:

1. Provision for the continued preservation of the historic property;
2. Limitations on the right to change the use, alter, demolish or convey the property; and
3. Provisions for public access to the historic property.

(b) The period of the easement is to be determined by the aggregate total of grant assistance made available under these regulations:

1. From $20,000 to $50,000—Five years;
2. From $50,001 to $100,000—10 years;
3. From $100,001 to $250,000—15 years;
4. From $250,001 to $500,000—20 years; and
5. From $500,001 and above—20 years or such additional period as the Trust may reasonably require.

SUBCHAPTER 5. PROJECT SIGNS

7:4C-5.1 Project signs

(a) Once a grant agreement has been executed for a project funded by historic preservation grant, a sign acknowledging that the project is funded with grant assistance from the New Jersey Historic Preservation Grant Program administered by the New Jersey Historic Trust in the New Jersey Department of Environmental Protection shall be located prominently and maintained on the project site.

(b) The project sign shall be fabricated and erected by the grant recipient in accord with specifications contained in the project agreement.

(c) The costs of making and erecting the project sign are eligible for funding under N.J.A.C. 7:4C-2.3(a)5. The costs of replacing or maintaining the sign are not eligible for funding.

SUBCHAPTER 6. FEES

7:4C-6.1 Fees

(a) To help defray costs of monitoring easements which are held on properties assisted through this program, an easement monitoring fee of $250.00 for each year of the term of the easement will be added to the recommended grant award for each project. The following is a schedule of easement fees:

1. Five years for a total of $1,250;
2. Ten years for a total of $2,500;
3. Fifteen years for a total of $3,750;
4. Twenty years for a total of $5,000;
5. Twenty-five years for a total of $6,200; and
6. Thirty years for a total of $7,500.

(a)

DIVISION OF FISH, GAME AND WILDLIFE
FISH AND GAME COUNCIL

Notice of Administrative Correction
1995-96 Fish Code
Special Regulation Trout Fishing Areas—Holdover Trout Lakes
Proposed Amendment: N.J.A.C. 7:25-6.9

Take notice that the Department of Environmental Protection has discovered an error in the text of the proposed amendment to N.J.A.C. 7:25-6.9(a) published in the July 18, 1994 New Jersey Register at 26 N.J.R. 2835(a). Numbered paragraph 5 in the proposal Summary correctly states the Fish and Game Council's intention to delete Canistear Reservoir in Sussex County from the list of Holdover Trout Lakes, which appear in N.J.A.C. 7:25-6.9(a). However, the proposed rule text at 26 N.J.R. 2837 inadvertently depicts the deletion of four other lakes as well. Through this notice, published in accordance with N.J.A.C. 1:30-2.7, the text of the proposed amendment is conformed to the Council's expressed intent.

Full text of the corrected proposed amendment, as it should have been published in the New Jersey Register, follows (addition indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:25-6.9 Special Regulation Trout Fishing Areas—Holdover Trout Lakes

(a) The following lakes are designated as Holdover Trout Lakes:

[1. Canistear Reservoir;]

Recodify existing 2. through 6. as **1. through 5.** (No change in text.)

(b) The following **shall** apply to the Holdover Trout Lakes designated at (a) above:

1.-2. (No change.)

3. A person shall not take, kill or have in possession, in one day, more than four in total of brook trout, brown trout, rainbow trout, lake trout or hybrids thereof, during the period extending from 8:00 A.M. April [9, 1994] **8, 1995** until May 31, [1994] **1995** or more than two of these species during the periods of January 1, [1994] **1995** to midnight March [20, 1994] **19, 1995 and June 1, 1995 through midnight March 18, 1996**. Trout, if taken during the period commencing at midnight, March [20, 1994] **19, 1995** and extending to 8:00 A.M., April [9, 1994] **8, 1995** must be returned to the water immediately and unharmed.

(b)

OFFICE OF AIR QUALITY MANAGEMENT

Enhanced Inspection and Maintenance Program
Proposed Amendments: N.J.A.C. 7:27-15.1; 7:27A-3.10; and 7:27B-4.1 and 4.5
Proposed Recodifications with Amendments: N.J.A.C. 7:27-15.2 as 15.3, 15.3 as 15.4, 15.4 as 15.6, 15.5 as 15.7, 15.6 as 15.8 and 15.7 as 15.9; and N.J.A.C. 7:27B-4.6 as 4.8
Proposed Repeal: N.J.A.C. 7:27-15.8 and Appendix II
Proposed New Rules: N.J.A.C. 7:27-15.2, 15.5 and 15.10; and 7:27B-4.6, 4.9, 4.10, 4.11 and Appendix 7
Proposed Repeal and New Rule: N.J.A.C. 7:27B-4.7

Authorized By: Robert C. Shinn, Jr., Commissioner, Department of Environmental Protection.
Authority: N.J.A.C. 13:1B-3(e), 13:1D-9, 26:2C-8 et seq., specifically 26:2C-8 and 8.1 through 8.5., and sections of P.L. 1993, c. 69.
DEP Docket Number: 37-94-07/407.
Proposal Number: PRN 1994-471.

A **public hearing** concerning this proposal will be held on:
Monday, September 12, 1994, 10:00 A.M. at:
New Jersey Department of Environmental Protection
Hearing Room, 1st Floor
401 East State Street
Trenton, NJ 08625

Submit written comments, identified by the DEP Docket Number given above, by September 19, 1994 to:
Janis Hoagland, Esq.
Office of Legal Affairs
New Jersey Department of Environmental Protection
CN 402
Trenton, N.J. 08625-0402

Several documents are cited within this notice as references or as documents being incorporated by reference. Copies of these documents may be requested from:
Dave West, Chief
Bureau of Transportation Control
Office of Air Quality Management
Department of Environmental Protection
CN 411
Trenton, N.J. 08625

Copies of the documents incorporated by reference may also be obtained from the Office of Administrative Law.

The agency proposal is set forth below. It contains six major components: (1) a "Summary" section which describes the purpose and scope of proposed rules; (2) a "Social Impact" section which describes the anticipated social effects of the proposed rules; (3) an "Economic Impact" section which sets forth the anticipated costs and benefits of the proposed rules; (4) an "Environmental Impact" section which sets forth the anticipated emission reductions to be obtained; (5) a "Regulatory Flexibility" section which examines the effect of the proposed rules on small businesses; and (6) the text of the proposed amended rules.

Summary

The Department of Environmental Protection (the Department) is proposing to amend and add new rules to N.J.A.C. 7:27-15 (Subchapter 15, Control and Prohibition of Air Pollution from Gasoline-Fueled Motor Vehicles), N.J.A.C. 7:27A-3.10 (Civil Administrative Penalties for Violations of Rules Adopted Pursuant to the Act) and N.J.A.C. 7:27B-4 (Subchapter 4, Air Test Method 4: Testing Procedures for Motor Vehicles), its rules governing standards, corresponding penalties, and testing procedures for the inspection of gasoline-fueled motor vehicles. This proposal supersedes the Department's previous two proposals, published on August 2, 1993 and December 6, 1993, at 25 N.J.R. 3322(a) and 5400(a) respectively. It is the Department's intent to prepare a summary of the comments submitted regarding to those proposals and the Department's responses thereto to be included in the notice of adoption should the Department determine to adopt the amendments and new rules contained in this proposal. A detailed description of this proposal's history is outlined more fully below.

The primary purpose of the proposed amendments and new rules is to reduce emissions of air pollutants from gasoline-fueled motor vehicles as part of New Jersey's overall effort to attain and maintain National Ambient Air Quality Standards (NAAQS) for carbon monoxide (CO) and ground-level ozone. Motor vehicles have been determined to be significant contributors of carbon monoxide, volatile organic compounds (VOCs) and oxides of nitrogen (NO_x). In the presence of sunlight, VOCs, NO_x and other compounds in the ambient air react to form ozone. Ozone is a known respiratory irritant and may significantly reduce the yield of important food crops. Ozone also causes degradation of paints, plastics, textiles and rubber.

In addition to their participation in the formation of ozone, NO_x alone exhibit serious human health effects. Although nitric oxide (NO) itself is a relatively nonirritating gas, it is readily oxidized to nitrogen dioxide (NO_2), which can damage respiratory defense mechanisms, allowing bacteria to proliferate and invade the lung tissue. Carbon monoxide is a poisonous gas at certain threshold levels. It is absorbed into the bloodstream and may have both direct and indirect effects on the cardiovascular system. A detailed description of the public health problems and damage to natural resources and property associated with increased levels of ozone, NO_x and carbon monoxide is presented below under the Social and Environmental Impact statements.

These proposed amendments and new rules are mandatory under the Clean Air Act (CAA), 42 U.S.C.A. §7401 et seq., as amended by the Clean Air Act Amendments of 1990 (CAAA), P.L. 101-549, November 15, 1990. Pursuant to the CAA, the United States Environmental Protection Agency (EPA) has established NAAQS for ozone as 0.12 parts per million (ppm) (one-hour average) and NAAQS for CO as nine ppm (eight-hour average) or 35 ppm (one-hour average). 42 U.S.C.A. §7409(a)(1), 40 CFR §50. The CAA requires certain areas which have failed to achieve the NAAQS to submit a State Implementation Plan (SIP) to the EPA which describes an enforceable plan for achieving and maintaining those standards within a prescribed time frame. 42 U.S.C.A. §7410.

New Jersey is subject to this requirement because not every county has attained the NAAQS for ozone and because certain urban areas have not attained the NAAQS for CO. The EPA has designated 18 of the State's 21 counties as being in "severe" nonattainment for ozone, based upon levels more than 50 percent above the NAAQS, that is, with a design value of 0.180 up to 0.280 ppm, in those areas. (Warren County is classified as marginal, that is, with a design value of 0.121 up to 0.138 ppm, and Atlantic and Cape May Counties are classified as moderate, that is, with a design value of 0.138 up to 0.160 ppm). A design value is the caliber that the EPA uses to indicate whether or not an area is in attainment with the NAAQS.

The CAAA further direct states in which serious or worse ozone nonattainment areas are located (New Jersey's 18 counties in severe nonattainment for ozone are worse than serious) to revise their SIPs to provide for an Enhanced Inspection and Maintenance (I/M) Program to reduce hydrocarbon (HC) and NO_x emissions from in-use motor vehicles registered in each urbanized area (in the nonattainment area) as defined by the Bureau of the Census, with a 1980 population of 200,000 or more. 42 U.S.C.A. §7511a(c)(3). In addition, the CAAA mandate that a state that is in an ozone transport region (as is New Jersey) provide for an enhanced I/M program in each area that is a metropolitan statistical area or part thereof with a population of 100,000 or more. 42 U.S.C.A. §7511c(b)(1)(A). The CAAA also direct states in which moderate nonattainment areas for CO with a design value greater than 12.7 ppm are located to revise their SIPs to provide for an enhanced I/M program to reduce CO emissions. 42 U.S.C.A. §7512a(a)(6). The Department, in cooperation with the Division of Motor Vehicles (DMV), is proposing to implement an enhanced I/M program Statewide, rather than county by county, in an effort to mitigate implementation and administration burdens and to increase air quality benefits.

As stated above, the State was required by the CAA to submit a revision to its SIP setting forth the elements of New Jersey's enhanced I/M program, including legal authority for its implementation, by November 15, 1993. Accordingly, the Department submitted SIP revisions, including the enhanced I/M program design, to the EPA on November 15, 1993. By a letter dated February 2, 1994 from William J. Muszynski, P.E., then Acting Regional Administrator of Region II of the EPA, to New Jersey Governor Christine Todd Whitman, the EPA notified the State that its November 15, 1993 SIP submittals did not meet the requirements for completeness established by the EPA and the CAA. In order to partially cure the defects of the original SIP submittals and secure the EPA's approval, the Department is now proposing implementing regulations for the enhanced I/M program. As a result of extensive and continuing negotiations with the EPA concerning the enhanced I/M program, the Department is confident that this proposal will meet with the EPA's approval and thereby prevent the application of federal sanctions against New Jersey.

New Jersey first implemented I/M standards for light-duty gasoline-fueled vehicles (under 6,000 pounds) on February 1, 1974. On July 1, 1983, the State phased in enhancements to the vehicle inspection program. These enhancements included tighter emission standards for light and heavy-duty vehicles and visual emission component inspections. In addition, the DMV began to license private reinspection centers as official inspection stations on a temporary basis. This designation eventually became permanent, thus creating the current hybrid design of Private Inspection Centers (PICs) and State-operated, centralized inspec-

tion stations under which the motorist has the option of having either an initial inspection or retest conducted by a PIC or a State station.

New Jersey's current I/M program consists of the annual inspection of all model years of gasoline-fueled light-duty and heavy-duty motor vehicles except for historical vehicles and motorcycles. At present, 80 percent of motorists use the centralized (State-operated) lanes, while 20 percent choose to use the decentralized PICs. Vehicle fleets of 10 or more vehicles may use on-site inspection services when licensed by the State as a private inspection center. Vehicles are tested for concentration measurements of carbon monoxide and HC from the vehicle exhaust with the engine running at a curb idle. All post-1980 vehicles are subject to standards of 1.2 percent carbon monoxide and 220 ppm HC. Pre-1980 vehicles are subject to less stringent standards. The State also performs a visual inspection of the catalytic converter and fuel inlet restrictor on all 1975 and later model year vehicles.

New Jersey's current inspection program provides for a 20 percent failure rate of pre-1981 model year vehicles for the initial emissions test. Windshield sticker surveys indicate that about 96 percent of the vehicles are complying with the inspection requirements. The program also provides for the on-road testing of approximately 40,000 motor vehicles as a supplement to the periodic inspection. The on-road test procedure is the same as the annual inspection test.

On November 5, 1992, the EPA, as required by 42 U.S.C.A. §7511a(a)(2)(B)(ii), published its final rule on I/M program requirements. See 40 CFR §51. Inspection/Maintenance Program Requirements; Final Rule. Specifically, 40 CFR §51.373(c)(1) provides that enhanced I/M programs shall be implemented as expeditiously as practicable. It provides further that enhanced I/M program shall be implemented by January 1, 1995, but that, where a test-and-repair network is being replaced by a test-only network, a state has until January 1, 1996 to phase in the change. The Department proposes that New Jersey's enhanced I/M program become operative on January 1, 1995, with enhanced inspections of at least 30 percent of the subject vehicle fleet performed by December 31, 1995. As the enhanced I/M program being proposed by the State is biennial (that is, every two years), this 30 percent of the subject vehicle fleet equates to 15 percent annually.

On August 2, 1993, the Department proposed its first set of amendments and new rules to N.J.A.C. 7:27-15 and 7:27B-4 at 25 N.J.R. 3322(a). At the same time, the DMV also pre-proposed new rules at N.J.A.C. 13:20-43 (Subchapter 43, Enhanced Motor Vehicle Inspection and Maintenance Program) at 25 N.J.R. 3418(a) to establish testing frequencies and other program design elements. The Department's proposed amendments and new rules, in conjunction with the DMV's pre-proposed new rules and anticipated changes to its enabling statute, N.J.S.A. Title 39, were intended to establish New Jersey's enhanced I/M program. On September 17, 1993, the Department and the DMV jointly held a public hearing to receive oral comment on the Department's proposed amendments and new rules and the DMV's pre-proposed new rules. These agencies accepted written comment on the proposal and pre-proposal, respectively, until the close of the comment period on September 24, 1993. It is the Department's intent to prepare a summary of the comments submitted regarding its two previous proposals and the Department's responses thereto to be included in the notice of adoption should the Department determine to adopt the amendments and new rules contained in this proposal.

The EPA has set forth the performance standard to be met by an enhanced I/M program at 40 CFR §51.351. The EPA developed the CAA- mandated performance standard using the IM240 test procedure as part of its model program design. A full description of the EPA-recommended IM240 exhaust emission and purge tests, incorporated by reference by the Department, can be found in an EPA report released in July of 1993 entitled "High-Tech I/M Test Procedures, Emission Standards, Quality Control Requirements, and Equipment Specifications." Interested parties may inspect a copy of this document at the Department's Public Access Center at 401 East State Street, First Floor, Trenton, New Jersey 08625 and/or obtain a copy of this document by contacting the Environmental Protection Agency, Office of Mobile Sources, Motor Vehicle Emission Laboratory, 2565 Plymouth Road, Ann Arbor, MI, 48105.

The performance standard established by the EPA is expressed in terms of reduced emission levels to be achieved from highway mobile sources as a result of the implementation of the enhanced I/M program. New Jersey's enhanced I/M program design must meet or exceed this minimum performance standard. Compliance with the performance standard is determined through computer modelling of the program parameters using the most current version of the EPA's mobile source emission factor model available at the time of SIP submission. The EPA has based the enhanced I/M performance standard on the following program design:

1. Network type: Centralized inspection system, with all testing to be performed at test-only State, State-licensed or State-authorized contractor-operated inspection lanes.

2. Implementation: Enhanced inspections of at least 30 percent of the subject vehicle fleet by December 31, 1995 and full program implementation by January 1, 1996.

3. Test frequency: Annual, although the EPA rule at 40 CFR §51.355(a) indicates other schedules may be approved if the required emission targets are achieved. EPA strongly recommends that States implement biennial test programs if they can demonstrate such equivalency.

4. Model year coverage: Testing of 1968 and later vehicles.

5. Vehicle type coverage: Light-duty gasoline-fueled vehicles and light-duty gasoline-fueled trucks, rated up to 8,500 pounds gross vehicle weight rating.

6. Exhaust emission test type:

a. Transient, mass emission testing on 1986 and later model year vehicles using the IM240 driving cycle;

b. Idle and 2500 RPM testing of 1981-1985 vehicles; and

c. Idle testing of pre-1981 vehicles.

7. Emission Standards: Exhaust emissions from 1986 and newer vehicles will be measured in terms of mass (grams per mile) rather than concentration (percent or parts per million); in addition to measuring HC and CO, the test will now also measure NO_x.

1994 and later vehicles meeting the Federal Tier I vehicle standards will be subject to standards more stringent than those for earlier model year vehicles. Tier I vehicles are those vehicles meeting Tier I standards, that is, those standards prescribed at 42 U.S.C.A. §7521(g) for model years 1994 and later light-duty gasoline-fueled trucks 1 (LDGT1s), and light-duty gasoline-fueled vehicles (LDGVs).

1981-1985 vehicles will be subject to the current 1.2 percent carbon monoxide and 220 ppm concentration HC standards.

8. Emission control device inspection: Visual inspection of the catalytic converter and the fuel inlet restrictor on all 1984 and later model year vehicles.

9. Evaporative system function checks:

a. Evaporative system integrity (pressure) test on 1983 and later model year vehicles to check for leaks in the hoses or connectors; and

b. Evaporative system functional (purge) test on 1986 and later model year vehicles to check for proper evaporative canister flow.

10. Stringency: At least 20 percent of pre-1981 model year vehicles will fail the initial emissions test.

11. Waiver rate: Three percent of all vehicle owners whose vehicles fail inspection may be exempted from meeting the emission standards.

12. Compliance rate: At least 96 percent of all vehicles subject to inspection must be inspected. Those vehicles not receiving a waiver or that are not inspected must be denied vehicle registration renewal.

13. Evaluation date: Enhanced I/M programs must demonstrate that the projected model program emission reductions are obtained by the year 2000 for HC and NO_x and by the year 2001 for CO, and for severe and extreme nonattainment areas, on each applicable milestone and the attainment deadline thereafter.

14. On-road testing: The program must include on-road testing of at least 0.5 percent of the subject vehicle population or 20,000 vehicles, whichever is less (for New Jersey, 20,000 vehicles is less), as a supplement to the periodic inspection. On-road testing can include both random roadside pullovers and remote sensing methods.

15. Sample testing: To provide a quantitative "rate of progress" measure, the program must include the testing of no less than 0.1 percent of the vehicle population using the transient IM240 test or equivalent test.

16. On-board diagnostics (OBD): (Reserved). The EPA has published its final rules concerning on-board diagnostics (February 19, 1993; 58 Fed Reg Vol 32, 9468-9488, generally at 40 CFR Part 86). These rules require new vehicles to be equipped with OBD systems, which assist in more accurately identifying vehicle malfunctions. By its rule, the EPA has these requirements phased in beginning with the 1994 model year. The EPA indicated that it expected to issue a notice of proposed rulemaking requiring OBD inspection by the states as part of I/M programs after promulgation of this final rule, but has not done so to

date. The Department expects to propose an amendment to its enhanced I/M regulations to provide for such an OBD inspection after the EPA promulgates such a requirement.

Although the EPA final rule at 40 CFR §51.357(a)(13) provides specific criteria for approval of alternative test procedures, the EPA has interpreted the relevant provisions of the CAA to provide states flexibility by employing the concept of a performance standard. Thus, a state may choose to vary any of the design elements of the model program (except those required by the CAA) provided the overall effectiveness of the program is at least as great as the performance standard, that is, as long as the numerical goal for emission reductions is attained. 57 FR 52953 (Nov. 5, 1992).

Consequently, the Department's August 2, 1993 proposal set forth two alternative emission testing procedures. The first test procedure, referred to in that proposal as Alternative Exhaust Test A (short transient), is essentially a shortened derivative of the IM240. This test utilizes the same analytical equipment as the IM240; however, only a portion of the driving schedule from the IM240 is used. As an alternative, the Department also set forth a second test procedure, referred to in that proposal as Alternative Exhaust Test B or the Acceleration Simulation Mode (ASM) 5015/2500 RPM test. The ASM5015 test is a steady-state, loaded mode emission test under which the vehicle is operated at 15 miles per hour under a constant load that is equivalent to 50 percent of the maximum load to which the vehicle is subjected as part of the Federal Test Procedure (FTP). The ASM5015 test is followed by a measurement of exhaust emissions with the engine operating at an unloaded engine speed of 2500 revolutions per minute (RPM). The equipment required for this test is less expensive and more easily obtained than that used by either the IM240 or Alternative Exhaust Test A.

The goal of the Department and the DMV has been to use the flexibility provided in the EPA's final rule on I/M program requirements to formulate an enhanced I/M program that would meet the performance standard in the most cost-effective manner possible with minimal inconvenience to the motoring public. Because the Department and the DMV projected that the emission tests proposed by the EPA would only be capable of processing about 8.5 vehicles per hour, they met with the EPA to express concern about the ultimate cost of the program. As a result, the EPA announced, at the September 17, 1993 public hearing on the August 2, 1993 proposal, the development of a "fast-pass/fast-fail" algorithm that would meet the performance standard. This "fast-pass/fast-fail" algorithm permits early termination of the IM240 exhaust emission test and the EPA-recommended purge test for those vehicles which would clearly pass or fail the full-length version of these tests. A purge test, which is designed to check the proper functioning of the vehicle's evaporative emission purge system, is performed simultaneously with an exhaust emission test.

As reported by the EPA, application of this algorithm would shorten the IM240's average test time from 240 seconds to approximately 115 seconds and would increase the throughput to 20 vehicles per hour. By a letter to the states from Eugene J. Tierney, Chief of the Inspection/Maintenance Section of the EPA's Office of Mobile Sources, dated September 13, 1993, the EPA has indicated its intent to promulgate rules to formally adopt the "fast-pass/fast-fail" algorithm, by proposing to amend 40 CFR with the addition of a new section, 85.2205(a)(4)-(5), but has not yet done so.

Furthermore, while the EPA has released tables setting forth second by second "fast-pass/fast-fail" standards for certain vehicle classes, proposed herein as Appendix II and incorporated by reference in the text of the rules, it has not provided such tables for all vehicle classes for either the interim standards (effective from implementation through 1997) or the final standards (effective 1998 and beyond). Emission standards for these vehicle classes shall be determined in accordance with the methodology used by the EPA and set forth at Appendix II. For any given vehicle type or model year, the "fast-pass/fast-fail" IM240 standards will be functionally equivalent to, and not more stringent than, those standards for the full IM240 test set forth in Table 4 at N.J.A.C. 7:27-15.6.

At the time of the Department's August 2, 1993 proposal, the EPA was still developing the "fast-pass/fast-fail" algorithm and had not yet made it available to the Department. In response to the EPA's announcement of the "fast-pass/fast-fail" algorithm at the September 17, 1993 public hearing, the Department proposed a supplement to the original amendments and new rules on December 6, 1993 at 25 N.J.R. 5400(a). In this supplement the Department proposed, in the alternative, a third exhaust emission test procedure at N.J.A.C. 7:27B-4.5 which utilized the EPA's IM240 test incorporating the "fast-pass/fast-fail" algorithm. In addition, the Department proposed, in the alternative, a third purge test procedure at N.J.A.C. 7:27B-4.6 which applied the EPA's "fast-pass/fast-fail" algorithm to the EPA-recommended purge test. Finally, in this supplement the Department proposed to amend N.J.A.C. 7:27A-3.10 to add specific monetary penalties corresponding to the amended and new anti-tampering provisions of the enhanced I/M program proposed on August 2, 1993.

Since August 31, 1992, the DMV has operated a demonstration test lane at its inspection station in Wayne, New Jersey. Operation of the ASM5015/2500 RPM test in that lane under "real-life" conditions has yielded a throughput as high as 23 vehicles per hour. On November 15, 1993, the DMV began operating the "fast-pass/fast-fail" IM240 exhaust test in that lane. Operation of this test under "real-life" conditions has yielded a throughput between 10 and 12 vehicles per hour. After observing the operation of that lane, the EPA believes that, with further procedural refinements, a minimum throughput of 15 vehicles per hour will be achieved, making the "fast-pass/fast-fail" IM240 exhaust test a cost-effective strategy in implementing an enhanced I/M program.

The Department has evaluated the results of the Wayne demonstration lanes and the findings of a number of other studies concerning the effectiveness of the various proposed exhaust and evaporative test procedures as well as public comment submitted in response to the August 2, 1993 and December 6, 1993 proposals. In consideration of the above, the Department hereby proposes amendments and new rules at N.J.A.C. 7:27-15, N.J.A.C. 7:27A-3.10, and N.J.A.C. 7:27B-4 which supersede those amendments and new rules proposed on August 2, 1993 and December 6, 1993. It is the Department's intent to prepare a summary of the comments submitted regarding to the two previous proposals and the Department's responses thereto to be included in the notice of adoption should the Department determine to adopt the amendments and new rules contained in this propsal.

These proposed amendments and new rules would establish test procedures and standards as part of a program design as follows:

1. **Network type:** Hybrid inspection system: vehicles more than four years old shall be inspected, and retested if necessary, at test-only facilities; vehicles less than five years old are permitted to be inspected and retested at a test-and-repair facility.

2. **Implementation:** Enhanced inspections starting by January, 1995 of at least 30 percent of the subject vehicle fleet with full program implementation by January 1, 1996.

3. **Test frequency:** Biennial, beginning with the second year of the vehicle's life. For more information on test frequency, see the DMV's pre-proposal of N.J.A.C. 13:20-43 at 25 N.J.R 3418(a), August 2, 1993.

4. **Test type, model year coverage and vehicle coverage:** The type of inspection a vehicle receives will depend on vehicle type and model year, as well as whether the inspection is performed at a centralized or decentralized station, as is illustrated in the following chart:

vehicle type	IM240 or ASM5015/ 2500 RPM[1]	curb idle	pressure test	purge test
LDGV[2] LDGT1[3] and LDGT2[4]	1968+	pre-1968	1975+	1975+
vehicle type	IM240 or ASM5015/ 2500 RPM[1]	curb idle	pressure test	purge test
HDGV[5]	N/A	ALL	N/A	N/A

[1]Motor vehicles during the 1st and 2nd inspection cycles which are inspected at a test-and-repair facility may receive an ASM5015/2500 RPM exhaust emission test instead of the IM240 exhaust emission test. In addition, if an inspection station finds it necessary to use the "switch" mechanism, described in detail below, a vehicle that visits this station during the "switch" would also be subject to an ASM5015/2500 RPM exhaust emission test.

[2]Light-duty gasoline-fueled vehicle.

[3]Light-duty gasoline-fueled truck 1 (GVWR of 0-6,000 lbs.).

[4]Light-duty gasoline-fueled truck 2 (GVWR of 6,001-8,500 lbs.).

[5]Heavy-duty gasoline-fueled vehicle.

In its final rule on I/M program requirements, the EPA has provided that states may operate a decentralized network if those states can demonstrate that a decentralized program is equally effective in achieving the enhanced I/M performance standard as a centralized test-only network. The Department, in conjunction with the DMV, believes that decentralized test-and-repair facilities provide added convenience to the motoring public primarily by allowing a vehicle to be tested, repaired and retested all at one location. For this reason, the Department and the DMV have sought to utilize the flexibility provided in the EPA's final rule to gain maximum participation of test-and-repair facilities in New Jersey's enhanced I/M program while continuing to meet the EPA's performance standard. Computer modelling using the EPA's mobile source emission factor model, MOBILE5a, has demonstrated that the maximum permissible test-and-repair participation achievable under the EPA's performance standard is limited to vehicles less than five years old. (For more information on the emission reductions of this program, see the Environmental Impact statement below.)

Under New Jersey's program design, vehicle owners in New Jersey are permitted to have their vehicles inspected at a test-and-repair facility, but only on their first and second inspection cycles (for two- and four-year-old vehicles, respectively). Subsequent inspections would have to be performed at test-only facilities. For example, a new vehicle, purchased from the manufacturer and registered in 1995, would be subject to an initial inspection two years later, in 1997. It would be subject to a second inspection two years after the initial inspection (that is, four years from the actual purchase date), that is, in 1999. Both of these inspections could be performed at a test-and-repair facility. However, starting with the third inspection in 2001 (six years from the actual purchase date), the vehicle could only be inspected at a test-only facility.

Vehicles tested at a test-and-repair facility, as stated previously, would be subject to an ASM5015/2500 RPM exhaust emissions test instead of the IM240 exhaust emission test. Test-and-repair facilities would also perform a pressure test and purge test during the inspection process. A visual check for the presence of catalytic converter would be performed on all vehicles inspected at a test-and-repair facility. However, vehicles inspected at test-only facilities would not be subject to any visual inspection. The more sophisticated equipment used at the test-only facilities would reveal if the catalytic converter were functioning properly or not and, thus, would eliminate the need for a visual inspection. Furthermore, those vehicles tested at a test- and-repair facility would be allowed to be retested (after a failure and repair) at a test-and-repair facility, as well.

Currently, the EPA is developing a test procedure known as the Repair Grade 240 (RG240). This test procedure, once developed, would use less expensive equipment than the IM240 and would allow repair shops to improve their ability to verify the adequacy of repairs made to vehicles which had previously failed the IM240 exhaust test without requiring them to invest in the more expensive IM240 equipment. The EPA's initial testing of the RG240 exhaust system demonstrates an acceptable correlation for repair verifications between the IM240 and the RG240 exhaust emission tests. The Department, in consultation with the DMV, views the RG240 test as a potential alternative exhaust emission test for the PICs should the EPA approve its use after it completes its development and evaluation of the procedure. The Department will continue to monitor the progress of the RG240 test and make a determination on its use as part of New Jersey's enhanced I/M program at a later date. Should the Department determine to approve this test for use by the PICs, it will amend N.J.A.C. 7:27-15 and 7:27B-4 accordingly. See SAE Technical Paper Series, "IM240 Repair Verification: An Inexpensive Dynamometer Method" by Jan B. Mickelsen and William B. Clemmens of the U.S. Environmental Protection Agency, February 28-March 3, 1994.

Fleet vehicles, defined by the EPA as vehicles that are part of a fleet of 10 or more vehicles, may be inspected on-site by the fleet owner for the first two inspection cycles (that is, years two and four), should the fleet owner choose to obtain a license from the DMV to operate as a PIC. In so doing, the fleet owner will be subject to the same requirements as any other PIC. However, as with all other vehicles subject to inspection in the State, a fleet vehicle must be inspected at a test-only facility on its third and all subsequent inspection cycles. As an alternative, fleet vehicles may be inspected by an outside contractor hired by the fleet owner to perform inspections. The contractor will be considered by the State as equivalent to a test-only facility. Thus, a fleet vehicle may be inspected by the contractor for all of its inspection cycles.

5. Emission Standards: The new standards for HC, CO and NO_x are set forth at N.J.A.C. 7:27-15.6(b)1 through (b)3 (Tables 1, 2, 3 and 4). Table 1 contains the standards for the idle test. Table 2 contains the standards for the 2500 RPM test, which is used in conjunction with the ASM5015 test. Table 3 contains the standards for the ASM5015 exhaust emission test. Table 4 contains the standards for the IM240 exhaust emission test. Finally, N.J.A.C. 7:27-15.6(b)4 (Appendix II) sets forth the standards for the "fast-pass/fast-fail" IM240 exhaust emission test.

1994 and later vehicles meeting the Federal Tier I vehicle standards will be subject to standards more stringent than the standards for pre-1994 non-Tier I vehicles. Tier I vehicles are those meeting Tier I standards, that is, those standards prescribed at 42 U.S.C.A. §7521(g) for model years 1994 and later LDGT1s, and LDGVs.

6. Emission control device inspection: Visual inspection of the catalytic converter on all vehicles subject to an inspection at a test-and-repair facility.

7. Evaporative system function checks:

a. Evaporative system integrity (pressure) test to check for leaks in the hoses or connectors on all applicable vehicles (see chart under item 4 above); and

b. Evaporative system functional (purge) test to check for proper evaporative canister purging on all applicable vehicles (see chart under item 4 above).

c. The Department is proposing two pressure tests and two purge tests. These tests are considered equivalent by the EPA and thus can be used interchangeably.

8. Stringency: Thirty percent of pre-1981 model year vehicles will fail the initial emissions test.

9. Waiver rate: The program modelling assumes that no more than three percent of all vehicles failing inspection will be exempted, for an inspection cycle, from meeting the inspection requirements by means of a cost waiver.

10. Compliance rate: At least 96 percent of all vehicles subject to inspection will be inspected. Those vehicles not receiving a waiver or that are not inspected shall be denied vehicle registration renewal.

11. Evaluation date: The Department will demonstrate that the emission reductions obtained by the enhanced I/M program meet or exceed those of the performance standard by the year 2000 for HC and NO_x and by the year 2001 for CO, and on each applicable milestone and attainment deadline, thereafter.

12. On-road testing: The program will include on-road testing of at least 20,000 vehicles as a supplement to the biennial inspection program. The on-road test will be the idle test as set forth at N.J.A.C. 7:27B-4.5. Standards for this test are set forth at N.J.A.C. 7:27-15.6 in Table 1. State or municipal police, depending on jurisdiction, will randomly pull over vehicles and DMV personnel will perform the inspection. In addition, the Department has reserved a subsection for remote sensing at N.J.A.C. 7:27-15.5(g) and is considering the use of this technology as a possible on-road screening tool.

13. Evaluation testing: To provide a quantitative "rate of progress" measure, the program will include the testing of no less than 0.1 percent of the vehicle population (that is, approximately 5,000 vehicles per year) using two complete IM240 tests.

14. On-board diagnostics (OBD): (Reserved). As discussed previously in the description of the OBD component of the EPA's performance standard, the Department will propose an amendment to its enhanced I/M rules to provide for OBD inspection after EPA finalizes its OBD rulemaking.

It has been the goal of the Department, in conjunction with the DMV, to design an enhanced I/M program that will maximize air quality benefit while minimizing adverse economic impact and consumer inconvenience. To ensure that program costs remain reasonable and that consumers are not unduly inconvenienced, the State has focused on a program design that will yield a throughput of at least 15 vehicles per hour in a biennial inspection program. However, while the EPA has assured the State that the "fast- pass/fast-fail" IM240 exhaust test can achieve this goal, the DMV's IM240 demonstration lane in Wayne, New Jersey has yet to achieve this throughput.

In order to achieve the EPA's performance standard, New Jersey will implement the "fast-pass/fast-fail" IM240 exhaust test at its centralized test-only facilities. The EPA has agreed to a program design which would allow test-only facilities to "switch" to the ASM5015/2500 RPM exhaust emission test under certain specified conditions for a limited time period (described below) would meet the performance standard and, therefore,

could be part of an approvable enhanced I/M SIP revision. This "switch" is designed and proposed only as a contingency measure should the projected throughput not be achieved and excessive waiting lines result.

A test-only facility will be permitted to "switch" to performing the ASM5015/2500 RPM exhaust emissions test in place of the "fast-pass/fast-fail" IM240 test if certain conditions exist. These conditions include assessment of customer waiting time, throughput, and the inspection station's hours of operation. The "switch" to the ASM5015/2500 RPM test will be permitted daily on a station-by-station basis. Once waiting time decreases to an acceptable level the station would be required to resume performing the "fast-pass/fast-fail" IM240 test procedure. In any event, all test-only inspection stations will begin each new business day by performing the "fast-pass/fast-fail" IM240 test procedure. Under certain conditions, this "switch" could be used more than once on any day at any given inspection station.

Anticipating that any developmental or start-up problems will be resolved by December 31, 1996, the Department's proposed rule provides that, as of January 1, 1997, inspection stations will no longer have the option of using the "switch" mechanism. However, the State will be conducting a study beginning no later than January 1, 1996 and concluding by July 1, 1996 to fully assess the performance of the IM240 exhaust emission test under "real-life" conditions. In the event that this study, which may also incorporate the findings from other states' research, determines that there are significant problems with the IM240 exhaust emission test, the State may wish to continue to make use of the "switch" mechanism after this date. In that case, the Department will propose a SIP revision and amendments to these rules. The "switch" mechanism is contained in proposed N.J.A.C. 7:27-15.5(h).

The ASM5015/2500 RPM exhaust test coupled with either set of evaporative pressure tests yields a significantly higher inspection lane throughput in comparison with the IM240, as demonstrated by the Wayne demonstration inspection lane. The DMV intends to design the new enhanced I/M program on the basis of a 15 vehicle per hour throughput. The provision of the "switch" mechanism will allow the State to attain or exceed this prescribed throughput, thus resulting in a cost savings from not having to construct additional inspection lanes. In addition, since the test-only facilities, if required to "switch," would perform the ASM5015/2500 RPM test on the same equipment used to performed the IM240 test, no significant capital costs will be needed to implement the "switch" mechanism. For more information on the capital and operational costs of this proposal, see the Economic Impact statement below.

This proposal is part of New Jersey's continually evolving comprehensive program to control motor vehicle emissions. Other components of the Statewide motor vehicle emission control plan include tighter new car standards, the use of cleaner fuels, including the Department's demonstration of alternatively-fueled vehicles, and the Department of Transportation's efforts to reduce motor vehicle use.

The specific provisions of the proposal are discussed in more detail below. It should be noted that, in drafting this proposal, the Department has made extensive modifications to the structure of N.J.A.C. 7:27-15 and 7:27B-4 including the redesignation and retitling of various sections within each subchapter. These structural modifications were made to ensure consistency and ease of interpretation of these subchapters.

Changes to N.J.A.C. 7:27-15

N.J.A.C. 7:27-15.1 Definitions

N.J.A.C. 7:27-15.1 defines terms used in subchapter 15. Certain definitions were updated to be consistent with the CAA and the new test procedures being proposed by the Department.

The definition of "approved exhaust gas analytical system" has been deleted and replaced with a new definition of "motor vehicle emission testing equipment," to encompass equipment used in the enhanced I/M program.

The definition of "carbon monoxide (CO)" has been modified to correct a typographical error.

The definition of "gasoline-fueled motor vehicle" is being deleted. The Department defines "gasoline-fueled" and "motor vehicle"; thus the definition is unnecessary.

The definition of "heavy-duty motor vehicle" has been replaced with a definition of "heavy-duty gasoline-fueled vehicle," which is defined as a vehicle with a gross vehicle weight rating in excess of 8,500 pounds. The substitution of this term in the Department's rules is consistent with the EPA's rules.

The term "light-duty motor vehicle" has been deleted, as this vehicle class is encompassed by "light-duty gasoline-fueled vehicle," which replaces it. The substitution of this term in the Department's rules is consistent with the EPA's rules.

The definition of "model year of vehicle" has been modified to remove the phrase "of vehicle" from the term and to clarify it.

The definition of "new motor vehicle" was changed to reflect the fact that motor vehicles are not registered prior to delivery in this State. Thus the clause "registered in New Jersey" was deleted from the definition.

The definition of "person" has been changed to include any individual or entity, without limitation, and to specifically include Federal and foreign entities, to broaden and clarify the definition.

The Department is proposing the following new definitions:

The definition of "air contaminant" is added to make references to pollutants uniform within this rule and for consistency with the Department's other rules.

The definition of "CARB," which refers to the California Air Resource Board, is added for the editorial convenience of referring to this agency by its initials.

The term "certified configuration" is added to define EPA-certified and California-certified vehicle designs as follows: for LDGVs and LDGTs, a vehicle-engine-chassis design and for HDGVs, an engine design. This term applies only to vehicles of model years 1968 and later certified by the EPA and vehicles of model years 1966 and later certified by CARB. Prior to these model years, the EPA and CARB did not certify motor vehicle configurations and thus the configuration of any vehicle prior to these model years is not regulated.

The definition of "Consumer Price Index (CPI)" is added to clarify the methodology by which the Department will determine the minimum cost expenditure for issuance of a cost waiver under N.J.A.C. 7:27-15.10.

As an associated change to "certified configuration," the term "element of design" is added to describe any automotive part or system associated with a vehicle's certified configuration that affects any EPA or California-regulated emissions. The amendments to subchapter 15 relating to anti-tampering provisions necessitate the addition of these definitions.

The definition of "EPA," which refers to the United States Environmental Protection Agency, is added for the editorial convenience of referring to this agency by its initials.

The term "EPA Memorandum 1A" is defined because it is used in the proposed changes at N.J.A.C. 7:27-15.7. use of the term clarifies which types of vehicle modifications do not constitute motor vehicle tampering.

The Department has defined "g/mi," which stands for grams per mile, to indicate the quantity of a given air contaminant.

The Department has defined "gasoline-fueled" to encompass alternative fuels in addition to gasoline.

The Department has defined "gross vehicle weight rating (GVWR)" to delineate vehicle classes for which it has established different emission standards. It is defined as the value specified by the manufacturer for the loaded weight of a single or combination vehicle.

The Department is proposing to add and define the following terms which are used in the proposed amendments to classify vehicles by form and function in order to determine the tests to which vehicles would be subject:

"Light-duty gasoline-fueled vehicle" or "LDGV," which is defined as a passenger car or passenger car derivative with a GVWR of 8,500 pounds or less; and

"Light-duty gasoline-fueled truck" or "LDGT," which is defined as a motor vehicle with a GVWR of 8,500 pounds or less with a vehicle curb weight of 6000 pounds or less and a basic frontal area of 45 square feet or less, designed for the transportation of property or for the transportation of persons numbering more than 12 or available with special features enabling off-street or off-highway operation.

LDGTs have been categorized to reflect the applicability of different test types and "fast-pass/fast-fail" standards, as follows:

"Light-duty gasoline-fueled truck 1" or "LDGT1," which is defined as a light-duty gasoline-fueled truck with a GVWR of 6,000 pounds or less; and

"Light-duty gasoline-fueled truck 2" or "LDGT2," which means a light-duty gasoline-fueled truck with a GVWR of more than 6,000 pounds.

The Department has added a definition of "loaded vehicle weight (LVW)" to delineate between standards applied to LDGTs in Table 4 at N.J.A.C. 7:27-15.6 for the IM240 exhaust emission test procedure.

The Department has added a definition of "motor vehicle emission testing equipment." This term is needed to distinguish it from current analytical equipment, which it replaces, to implement the enhanced I/M program. The Department anticipates proposing new equipment specifications later this year for equipment that is approvable by both the EPA and the Department. These specifications will be found at a new Appendix 7 to N.J.A.C. 7:27B, which the Department reserves at this time.

The Department has defined "oxides of nitrogen (NO_x)" because the proposed enhanced I/M program will, in addition to testing for HCs and CO, test for the excessive emission of NO_x.

The term "professional repair technician" is added to identify those individuals who are authorized to perform emission-related repairs which may qualify for a cost waiver (see N.J.A.C. 7:27- 15.10(d)).

"Quasi-public property" is added to extend the applicability of certain prohibitions contained in subchapter 15 to areas that are privately owned yet which are publicly accessible to motor vehicles.

"RPM," which means revolutions per minute, is added to describe the engine speed at which the 2,500 RPM test is performed.

"Tier I Standards" is added to differentiate among vehicle types in setting the "fast-pass/fast-fail" standards for the IM240 exhaust emission test.

The Department has added a definition of "vehicle curb weight" because it is used in the definition of "light-duty gasoline-fueled truck".

N.J.A.C. 7:27-15.2 Applicability

The Department is adding this section to clarify which vehicle types are regulated under this subchapter. Also included within this section are specific vehicle types which are exempt from this subchapter.

N.J.A.C. 7:27-15.3 General public highway standard

The Department is proposing to update the public highway standard currently found at N.J.A.C. 7:27-15.2. In addition to regulating the emission of HC and CO on any road, street or highway of the State or any public or quasi-public property in the State, the Department is proposing to also regulate the emission of NO_x. This proposed change would make the emission standards referenced by the highway standard consistent with those proposed for the enhanced I/M program. The new standards for HC, CO and NO_x are set forth at N.J.A.C. 7:27-15.6(b)1 through 3 (and Tables 1, 2, 3 and 4 thereunder) and N.J.A.C. 7:27-15.6(b)4 (and Appendix II).

The Department has added a subsection at N.J.A.C. 7:27-15.3(c) that prohibits the operation of a motor vehicle on any public highway unless all motor vehicle inspection testing requirements at N.J.A.C. 7:27-15.5 are met.

Also, the Department has added a subsection at N.J.A.C. 7:27-15.3(d) that prohibits the operation of vehicles not in a certified configuration for vehicle model years 1968 and later (certified by the EPA) and for vehicle model years 1966 and later (certified by CARB). Prior to these model years, the EPA and CARB did not certify motor vehicle configurations and thus the configuration of any vehicle prior to these model years is not regulated.

N.J.A.C. 7:27-15.4 New motor vehicle dealer inspections

The reference to inspection standards contained in this section is changed from N.J.A.C. 7:27-15.4(b) to N.J.A.C. 7:27-15.6(b). This change reflects the recodification of N.J.A.C. 7:27-15.4 to 7:27-15.6.

N.J.A.C. 7:27-15.5 Motor vehicle inspection testing

The Department is proposing a new rule at N.J.A.C. 7:27-15.5 to explain which test procedures constitute a motor vehicle inspection and which vehicle types and model years are subject to each test procedure. The section consolidates the various motor vehicle inspection testing requirements.

N.J.A.C. 7:27-15.5(a) requires that all motor vehicles subject to inspection shall be periodically inspected in accordance with the section. N.J.A.C. 7:27-15.5(b) specifies that in order for a motor vehicle to pass inspection it must pass all of the tests that constitute the inspection.

N.J.A.C. 7:27-15.5(c) provides that all motor vehicles must be inspected by a test-only inspection facility, with two exceptions. LDGVs, LDGTs and HDGVs which are less than five model years old may be inspected at a PIC licensed by the DMV. Motor vehicles which are part of a fleet and which are less than five model years old may be self-inspected by the fleet operator, so long as said operator obtains a PIC license from the DMV. As an alternative, fleet vehicles may be inspected by an outside contractor hired by the fleet owner to perform inspections. The contractor will be considered by the State as equivalent to a test-only facility. Thus, a fleet vehicle may be inspected by the contractor for all of its inspection cycles.

The frequency with which a motor vehicle must be inspected is set forth at N.J.A.C. 7:27-15.5(d). The enhanced I/M program in New Jersey will be on a biennial basis, that is, each vehicle will be inspected every two years. For more information concerning inspection frequency, see the DMV's pre-proposal of N.J.A.C. 13:20-43.2 at 25 N.J.R, 3418(a), August 2, 1993.

N.J.A.C. 7:27-15.5(e) specifies that a motor vehicle inspection must consist of the following: (1) a visible smoke test; (2) an exhaust emission test; (3) a catalytic converter check on those vehicles subject to inspection at a test-and-repair facility; (4) an evaporative pressure test on post-1974 LDGVs, LDGT1s and LDGT2s; (5) an evaporative purge test on post-1974 LDGVs, LDGT1s and LDGT2s; and (6) proof that all emissions recall repairs have been performed.

N.J.A.C. 7:27-15.5(f) outlines on-road testing requirements as (1) a visible smoke test; and (2) an idle test. The Department has reserved N.J.A.C. 7:27-15.5(g) for the possible use of remote sensing techniques.

All motor vehicles are required to have an exhaust emission test. N.J.A.C. 7:27-15.5(h) establishes which exhaust test a vehicle must undergo, depending upon factors such as vehicle model year and vehicle type, at which stage of implementation of the enhanced I/M program the vehicle is inspected, and whether the vehicle is inspected at a test-only or a test-and-repair facility. Based on these factors, a vehicle will undergo one of the following exhaust tests: (1) the idle test, (2) the ASM5015/2500 RPM test, (3) the IM240, or (4) the "fast-pass/fast-fail" IM240. For a detailed discussion of the nature and applicability of these exhaust tests, see the chart in the Summary section above.

The EPA's rules at 40 CFR §51.353(c) require that 0.1 percent of the vehicle population subject to inspection in a given year be evaluated using a full 240 second IM240 exhaust test. The testing of this representative, randomly selected set of vehicles will be used as an evaluation tool for the new enhanced I/M program. Accordingly, the Department is proposing to add this testing requirement at N.J.A.C. 7:27-15.5(i), providing that those vehicles subject to evaluation testing shall receive an IM240 test, performed in accordance with the procedures specified at N.J.A.C. 7:27B-4.7(d), in addition to the testing requirements at N.J.A.C. 7:27-15.5.

N.J.A.C. 7:27-15.5(j) specifies the requirements for the reinspection of a motor vehicle.

N.J.A.C. 7:27-15.6 Motor vehicle inspection standards

The Department is proposing several changes to the inspection standards set forth at N.J.A.C. 7:27-15.6 to be consistent with the new inspection procedures. N.J.A.C. 7:27-15.6(b)1, 2, 3 and 4 are added to specify where the standards may be found for each exhaust emission test procedure. Regulatory Appendix 1 and Tables 2, 3 and 4 contain the new standards. In addition, the Department is reserving standards within Tables 2, 3, and 4 to be used for vehicles powered by a fuel other than gasoline. The Department has reserved these standards in an effort to address the issue of possible false failures of alternatively-fueled vehicles. The standards being proposed by the Department are designed for total HC measurement. Some alternatively-fueled vehicles emit large quantities of the HC methane, which is an inert compound relatively harmless to the environment. However, if tested using the proposed standards, these alternatively-fueled vehicles may mistakenly be identified as high emitters and, consequently, fail the exhaust test. As such, the Department is reserving standards for alternatively-fueled vehicles until standards designed for non- methane HC measurement are developed.

Table 4 at N.J.A.C. 7:27-15.6(b) contains the standards to be used with the IM240 exhaust emission test. The new emission standards for the proposed IM240 exhaust emission test are to be phased-in in two stages. The first set of standards is effective from January 1, 1995 until December 31, 1997, after which the second set of more stringent standards becomes effective. The delayed implementation of more stringent standards should serve to reduce the anticipated high initial failure rate during the phase-in period.

Appendix II sets forth the "fast-pass/fast-fail" standards developed by the EPA to be used when performing a "fast-pass/fast-fail" IM240 exhaust emission test. To date, the EPA has developed and made available to the Department the interim "fast- pass/fast-fail" standards (to be used from January 1, 1995 through December 31, 1997) for the following categories of vehicles: LDGVs, for model years 1983-1990; LDGVs, model years 1991-1995, not including 1994 and 1995 vehicles

certified to Tier 1 standards; and LDGVs, model years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles. EPA has also developed and made available to the Department the final "fast-pass/fast-fail" standards (to be used from January 1, 1998 and forward) for LDGVs, for model years 1983-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards. Emission standards for those vehicle classes which have not been provided by the EPA shall be determined in accordance with the methodology used by the EPA and set forth at Appendix II. For any given vehicle type or model year, the "fast-pass/fast-fail" IM240 standards will be functionally equivalent to, and not more stringent than, those standards for the full IM240 test set forth in Table 4 at N.J.A.C. 7:27-15.6.

The use of the "fast-pass/fast-fail" algorithm allows a vehicle to pass or fail the exhaust emissions test without completing the full 240 second driving cycle if the vehicle exhibits emissions levels such that the vehicle would clearly pass or fail the full IM240 exhaust emission test. Otherwise, the test is run for the entire 240 second duration to determine whether the vehicle passes or fails. The Department has included in Appendix II to these rules, and incorporated therein by reference, the algorithm distributed by the EPA.

The standards to be used in performing the ASM5015 exhaust emission test are contained in Table 3 of N.J.A.C. 7:27-15.6(b). There are both interim and final standards for use with the ASM5015 test. The interim standards will be used from January 1, 1995 through December 31, 1997, at which time the final standards become effective. However, in order for a vehicle to pass this emission test, it must also meet the specified standards for the 2500 RPM test, as set forth in Table 2.

New provisions at N.J.A.C. 7:27-15.6(d), (e) and (f) account for the appropriate inspection of vehicles in which the engine or fuel type has been changed and for vehicles that are manufactured or modified to operate on more than one fuel type.

N.J.A.C. 7:27-15.7 Prohibition of tampering with emission control apparatus

The Department is proposing amendments at N.J.A.C. 7:27-15.7 which prohibit any changes to a vehicle's certified configuration or element of design and the operation of such a modified vehicle on any road, street or highway of the State or any public or quasi-public property in the State. The Department would allow those modifications which are made in accordance with the EPA Memorandum 1A or approved by CARB executive order. Memorandum IA and a CARB executive order are the only two sources authorized by the Federal government to allow changes to a motor vehicle's certified configuration.

The amendment would prohibit the offering for sale or lease of any vehicle which has been tampered with, that is, in which any element of design has been disconnected, detached, deactivated, or in any other way rendered altered or modified from the design of the original vehicle manufacturer. The expansion of the prohibition to offers for sale and offers for lease addresses the enforcement problem the Department has experienced under the current rule, which prohibits only the actual sale of a tampered vehicle.

To further discourage tampering with an element of design, the Department is also proposing to prohibit the sale and offering for sale of components that are not designed to duplicate the function and performance of the original element of design unless these components are sold by the original vehicle manufacturer or are approved by CARB executive order as identical replacement parts. See CAA 203(a)(3)(B).

The intent of the provisions at N.J.A.C. 7:27-15.7 is solely to prohibit any modification to a motor vehicle which would increase its emissions and consequently, negatively affect air quality. It is not the intention of the Department to have this section apply to modifications which do not affect vehicle emissions.

N.J.A.C. 7:27-15.8 Idle standard

The Department's current idle standard, set forth at N.J.A.C. 7:27-15.6, prohibits the idling of a gasoline-fueled motor vehicle for more than three consecutive minutes if the vehicle is not in motion, with two exceptions. The first exception allows an extended warm-up period of 30 consecutive minutes for vehicles operating on private property or at their permanent place of business; the second allows a warm-up period of 15 consecutive minutes for vehicles which have had their engines stopped for three or more hours. Since whatever convenience these exceptions might have originally provided is now far outweighed by the need to reduce unnecessary emissions, the Department is eliminating them from the idle standard proposed for amendment at N.J.A.C. 7:27-15.8. The Department is proposing no modifications to the provisions currently found under N.J.A.C. 7:27-15.6(b), which identify specific exemptions to the idle standard.

N.J.A.C. 7:27-15.9 Non-interference with the motor vehicle codes

The Department is proposing to eliminate the exception from applicability of this subchapter for vehicles with an engine displacement of less than 50 cubic inches (819 cubic centimeters) currently found at N.J.A.C. 7:27-15.7. The EPA's final rule on I/M program requirements does not permit the exception of these vehicles; they set no minimum weight or engine size limitation. The exception for motorcycles has been moved to N.J.A.C. 7:27-15.2 Applicability. N.J.A.C. 7:27-15.7, as proposed for recodification to N.J.A.C. 7:27-15.9, will contain, unmodified, the provision currently found at N.J.A.C. 7:27-15.7(b).

N.J.A.C. 7:27-15.8 Variances

The Department is proposing to eliminate the current provision at N.J.A.C. 7:27-15.8, under which the Commissioner of the Department or the Director of the DMV may prescribe alternative emission inspection standards for vehicles deemed incapable of complying with the provisions of N.J.A.C. 7:27-15.4(b) (recodified, with changes, to N.J.A.C. 7:27-15.6(b)). The provision is inconsistent with EPA guidance at 40 CFR 51.360(b). The Department believes that the new rule on waivers, proposed at N.J.A.C. 7:27-15.10, will achieve the same end as the variance in a less subjective manner.

N.J.A.C. 7:27-15.10 Cost waiver

The Department is proposing a new section to establish criteria which would allow a motorist, under limited circumstances, to be relieved from the Department's inspection requirements set forth at N.J.A.C. 7:27-15.5 and from the DMV's inspection requirements set forth at Title 39 and N.J.A.C. 13:20-43.2. The Department's rule establishes a cost waiver. The Department believes that the proposed waiver option will sufficiently mitigate inconvenience and economic hardship to the motorist without significantly decreasing the emission reductions expected to be gained by the enhanced I/M program.

For most vehicles, the cost of repairs needed to pass the emissions tests will not be excessive and will be significantly offset by the reduction in fuel consumption that is associated with repairs to malfunctioning emission control systems. However, the Department recognizes that for some vehicles the cost of repairs may not be cost effective; in some cases the cost of repair may exceed the value of the vehicle.

To address these concerns, consistent with the requirements established by the EPA at 40 CFR 51.360, the Department is proposing a cost waiver. After meeting certain criteria, a motorist who has spent a minimum of $450.00 on emission-related repairs to bring a failed vehicle into conformance could apply for a cost waiver, which would be effective until the vehicle is next due for inspection. This process would have to be repeated for any inspection cycle where the vehicle fails the emission test, repairs exceed $450.00, and the motorist again desires a single test cycle waiver for repair costs in excess of $450.00. The $450.00 minimum expenditure will be adjusted in January of each year by the percentage, if any, by which the Consumer Price Index (CPI) for the preceding year differs from the CPI for 1989. See proposed N.J.A.C. 7:27-15.10(e). The CPI figure for 1989 is 124.0. The most current CPI figure to date is 143.2 for the year 1993. The most recent CPI figure is the calculated average of the CPIs over the 12-month period beginning August 1992 and ending August 1993, as specified in the EPA's final rule on I/M program requirements. For example, if the enhanced I/M program was in effect now, the minimum expenditure in 1994 to qualify for a cost waiver would be $519.68.

An applicant for a cost waiver will be required to provide documentation indicating that any available emission-related warranty coverage has been used or that warranty coverage for needed repairs has been denied by the manufacturer or authorized dealer before the waiver can be issued.

The EPA's rules at 40 CFR §51.360(d)(1) require that the SIP include a maximum waiver rate expressed as a percentage of initially failed vehicles, which will be used for estimating emission reduction benefits in the modelling analysis. For an enhanced I/M program, the EPA suggests that this waiver rate be three percent. New Jersey has accepted the EPA's suggested waiver rate and, thus, the number of waivers issued by the State in a given calendar year will not exceed three percent of the total number of vehicles that fail initial inspection. If New Jersey exceeds this three percent waiver rate, the State will lose emission credit for the enhanced I/M program towards its attainment goal and will have

to take corrective action to make up for the loss. This might result in the implementation of additional emission reduction strategies. However, the State believes that exceedance of the three percent waiver rate is unlikely.

During its two previous proposals, the Department had requested comment on the issuance of waivers. To date, no comments on a waiver program have been received by the Department. The Department is again soliciting comment on the issuance of waivers and encourages the public to submit recommendations on waiver types and methodologies.

Changes to N.J.A.C. 7:27A

N.J.A.C. 7:27A-3.10 Civil administrative penalties for violations of rules adopted pursuant to the Act

The Department is proposing to amend the N.J.A.C. 7:27A-3.10(e)15 civil administrative penalty schedule for violations of N.J.A.C. 7:27-15. Several new provisions and amendments of the existing penalty provisions are described below.

The Department is proposing amendments at N.J.A.C. 7:27A-3.10(e)15 to establish penalties for the violation of proposed N.J.A.C. 7:27-15.3(d), which prohibits the operation on any road, street or highway of the State or any public or quasi-public property in the State of any motor vehicle that is not of a certified configuration for specific model years.

The penalties for N.J.A.C. 7:27-15.3(d) are the same as those for N.J.A.C. 7:27-15.7(a)2, which are the penalties for driving a tampered vehicle. The emissions generated by driving a motor vehicle in a non-certified configuration would be similar to those generated by driving a tampered vehicle. The Department determined that the environmental degradation caused by these two activities would be similar and thus, the penalties are also identical.

The Department is also proposing amendments at N.J.A.C. 7:27A-3.10 to establish penalties for the violation of proposed N.J.A.C. 7:27-15.7(a)3, which prohibits leasing or offering for sale or lease a tampered vehicle, that is, a vehicle with a certified configuration in which any element of design has been disconnected, detached, deactivated, or in any other way altered or modified from the design of the original vehicle manufacturer. These penalties are identical to those imposed under the current rules for the sale of vehicles with tampered emission control devices.

The penalties for violations of N.J.A.C. 7:27-15.7(a)3 distinguish between an owner of four or fewer vehicles and an owner of five or more vehicles (for example, a fleet owner). This distinction was made to be consistent with the penalties imposed for violations of the provisions of N.J.A.C. 7:27-15.7(a)1. When the penalties at N.J.A.C. 7:27A-3.10(e)15 were originally developed, individuals typically owned two vehicles or less. Currently, individual vehicle ownership exceeds, on average, three vehicles. Therefore, the number of vehicles owned by one person was changed at N.J.A.C. 7:27A-3.10(e)15 to more accurately reflect the individual ownership of multiple vehicles. This ensures that an individual who owns multiple vehicles is not mistakenly assessed a penalty more appropriate for a fleet owner or motor vehicle dealership. The penalties for fleet vehicles are more severe due to the greater contribution of their emissions to the degradation of air quality.

Finally, the Department is proposing amendments at N.J.A.C. 7:27A-3.10 to establish penalties for the violation of proposed N.J.A.C. 7:27-15.7(a)4, which prohibits the sale or offering for sale of emission control defeat devices. The sale of a device or component that is not designed to duplicate the function and performance of any element of design installed in a vehicle with a certified configuration by the original vehicle manufacturer has the same potential for causing increased emissions and environmental degradation as the sale or lease of a tampered vehicle. Since the effects of the two kinds of violations are virtually indistinguishable, the Department is proposing penalties for violations of N.J.A.C. 7:27-15.7(a)4 equal to those already established for violations of N.J.A.C. 7:27-15.7(a)3 for owners of more than four vehicles. The inclusion of these penalties requires modification of the introductory language at N.J.A.C. 7:27A-3.10(e)15 to make clear that the civil administrative penalty amounts for each violation of N.J.A.C. 7:27-15.7(a)4 will be imposed per device or per component.

The proposed new penalties are intended to ensure compliance with the proposed new and amended sections of N.J.A.C. 7:27-15. The penalties for violations of proposed new N.J.A.C. 7:27-15.3(d) and proposed amended N.J.A.C. 7:27-15.7(a)1, 15.7(a)2, 15.7(a)3, and 15.7(a)4 are consistent with penalties for violations of similar requirements in N.J.A.C. 7:27-15. In establishing the proposed penalty amounts, the Department has applied the following criteria:

1. The potential or actual health and environmental impacts of the violation, including the characteristics and quantity of the air contaminants regulated, the magnitude of the areas affected and the air quality of the area affected;
2. The deterrent value of the penalty and whether the proposed penalty amounts are appropriate to ensure compliance with N.J.A.C. 7:27-15; and
3. Consistency with penalties in N.J.A.C. 7:27A-3.10 for violations of other comparable rules in N.J.A.C. 7:27.

Changes to N.J.A.C. 7:27B-4

N.J.A.C. 7:27B-4.1 Definitions

N.J.A.C. 7:27B-4.1 defines terms used in subchapter 4, which contains the rules regarding testing procedures for motor vehicle emissions. Certain definitions are being updated to be consistent with the CAA and with the new test procedures being proposed by the Department.

The term "chassis dynamometer" is modified to include "dynamometer" and the definition is modified to correct a typographical error.

The term "diesel-powered motor vehicle" is replaced with "heavy-duty diesel vehicle (HDDV)." The new definition specifies a minimum weight in excess of 8,500 pounds and reflects the vehicle's use of diesel oil as its fuel.

The definition of "gasoline-fueled motor vehicle" is being deleted. The Department defines "gasoline-fueled" and "motor vehicle"; thus the definition is unnecessary.

The term "heavy-duty motor vehicle" is replaced with "heavy-duty gasoline-fueled vehicle," which is defined as a vehicle with a gross vehicle weight rating in excess of 8,500 pounds. The substitution of this term in the Department's rules is consistent with the EPA's rules.

The definition of "light-duty motor vehicle" has been deleted, as it has been in subchapter 15. This vehicle class is encompassed by the new definition of "light-duty gasoline-fueled vehicle." The substitution of this term in the Department's rules is consistent with the EPA's rules.

The Department is also proposing to add definitions consistent with the proposed enhanced I/M testing procedures.

The definition of "EPA," which refers to the United States Environmental Protection Agency, is added for the editorial convenience of referring to this agency by its initials.

The Department has defined "gasoline-fueled" to encompass alternative fuels in addition to gasoline.

The Department has defined "gross vehicle weight rating (GVWR)" to delineate vehicle classes for which it has established different emission standards. It is defined as the value specified by the manufacturer for the loaded weight of a single or combination vehicle.

The terms "inertia weight" and "vehicle curb weight" are added in order to describe the calculation of the dynamometer load used for the proposed emission tests. "Vehicle curb weight" is the actual weight of the vehicle in operational status; "inertia weight" is defined as the vehicle curb weight plus 300 pounds.

As in subchapter 15, the Department is proposing to add and define the following terms which are used in the proposed amendments to classify vehicles by form and function in order to determine the tests to which vehicles would be subjected:

"Light-duty gasoline-fueled vehicle" or "LDGV," which is defined as a passenger car or passenger car derivative with a GVWR of 8,500 pounds or less; and

"Light-duty gasoline-fueled truck" or "LDGT," which is defined as a motor vehicle with a GVWR of 8,500 pounds or less with a vehicle curb weight of 6,000 pounds or less and a basic frontal area of 45 square feet or less, designed for the transportation of property, or for the transportation of persons numbering more than 12, or with the availability of special features enabling off-street or off-highway operation.

LDGTs have been categorized to reflect the applicability of different test types and "fast-pass/fast-fail" standards, as follows:

"Light-duty gasoline-fueled truck 1" or "LDGT1," which is defined as a light-duty gasoline-fueled truck with a GVWR of 6,000 pounds or less; and

"Light-duty gasoline-fueled truck 2" or "LDGT2," which means a light-duty gasoline-fueled vehicle with a GVWR of more than 6,000 pounds.

As in subchapter 15, the Department has added a definition of "motor vehicle emission testing equipment." This term is needed to distinguish new equipment from current analytical equipment which will be replaced when the enhanced I/M program is implemented. The Department

anticipates proposing new specifications later this year for equipment that is approvable by both the EPA and the Department. These specifications will be found at a new Appendix 7 to N.J.A.C. 7:27B, which the Department reserves at this time.

"Tier I Standards" is added, as it is in subchapter 15, to differentiate among vehicle types in setting the "fast-pass/fast-fail" standards for the IM240 exhaust emission test.

N.J.A.C. 7:27B-4.5 Procedures for the visible smoke test and the idle test

The Department is not proposing any substantive changes to the existing smoke test described at N.J.A.C. 7:27B-4.5(a) or the existing idle test described at N.J.A.C. 7:27B-4.5(b). However, the Department is proposing structural modifications and updates to standard references within this section.

N.J.A.C. 7:27B-4.6 Procedure for the ASM5015 test and the 2500 RPM test

The Department is proposing to add a new exhaust emission test procedure, the ASM5015 test coupled with the 2500 RPM test. The ASM5015 exhaust emission test procedure consists of a steady-state loaded mode test followed by a 2500 RPM, high idle test. The Department believes that this combination of tests yields a better overall correlation with the FTP than either test alone. The ASM5015 test involves operation of the vehicle on a dynamometer at a constant speed of 15 MPH under a load which is calculated to subject the vehicle to 50 percent of the maximum acceleration rate of the FTP driving cycle. The ASM5015 test duration is 90 seconds with a fast pass at 30 seconds if the exhaust concentrations are significantly below the standards. The 2500 RPM test is conducted with the vehicle's engine running at a speed of 2500 RPM for 30 seconds. In order for a vehicle to pass this emission test procedure, it must meet the specified standards for both the ASM5015 test and the 2500 RPM test.

In test-and-repair facilities, the ASM5015/2500 RPM test uses a Bureau of Automotive Repair (BAR) 90 analyzer, which measures emission concentrations, and a non-transient dynamometer. However, test-only facilities, if required to "switch" to the ASM5015/2500 RPM, will perform this test on the equipment used to perform the IM240 test. For a more detailed discussion of implementation and operation costs of this test procedure, refer to the Economic Impact statement below.

N.J.A.C. 7:27B-4.7 Procedures for the IM240 test and the fast-pass/fast-fail IM240 test

The Department is also proposing to add two exhaust emission test procedures, the IM240 test and the IM240 test utilizing the "fast-pass/fast-fail" algorithm. The IM240 is a 240 second driving cycle which employs a series of accelerations and decelerations and simulates typical driving conditions, such as road friction and drag. The test is accomplished by operating the vehicle with its drive wheels on a dynamometer. The "fast-pass/fast-fail" algorithm allows early termination of the test for those vehicles whose emission levels indicate that they would clearly pass or fail the IM240 emission test if it were to run for the full 240 seconds. Exhaust emission samples are collected from the tailpipe and expressed in terms of mass (g/mi).

The equipment used in performing the IM240 exhaust emission test, whether or not the test employs the "fast-pass/fast-fail" algorithm, includes mass emission sampling and an emission analysis system in conjunction with a transient mode dynamometer. Capital costs to implement the IM240 and the evaporative tests biennially under the program being proposed are estimated at between $74 and $108 million and it is anticipated that this test equipment will be more expensive to operate. For a more detailed discussion of implementation and operation costs of the IM240 exhaust emission test, refer to the Economic Impact statement below.

The new provisions above replace the existing N.J.A.C. 7:27B-4.7, Gasoline-fueled motor vehicle exhaust lead determination procedure. The Department is proposing to repeal the requirements of the original N.J.A.C. 7:27B-4.7, which, pursuant to the provisions of N.J.A.C. 7:27B-4.7(f), expired on October 1, 1986. Originally, the Department included this provision to collect data on the presence of lead in vehicle exhaust. The Department only planned to collect enough information to determine the quantity of lead present in vehicle exhaust and thus, added a specific expiration date to the provision.

N.J.A.C. 7:27B-4.8 Emission control apparatus examination procedure

The Department is proposing to eliminate the examination for the fuel inlet restrictor. As leaded gasoline is generally not available in New Jersey and neighboring states, this examination is no longer necessary. In addition, as of 1995, leaded gasoline will be banned nationwide. The Department plans to retain the visual examination for the presence of properly installed catalytic converters. This type of visual inspection will be performed only on vehicles subject to inspection at a test-and-repair facility. Vehicles inspected at a test-only facility will not be subject to a visual inspection for the catalytic converter, as the equipment that will be used in these facilities is sophisticated enough to detect whether or not the catalytic converter is functioning properly.

N.J.A.C. 7:27B-4.9 Procedures for the evaporative pressure test

The Department is proposing to add tests of each vehicle's evaporative pressure system at N.J.A.C. 7:27B-4.9, as required by the EPA's final rule on I/M program requirements at 40 CFR 51.357(a)(10).

Evaporative emissions from a vehicle's fuel storage and delivery systems constitute a significant source of volatile organic compound (VOC) emissions. To date, I/M programs have not effectively tested evaporative emission control systems for integrity and function. The Department is proposing two evaporative pressure tests for use in New Jersey's enhanced I/M program. In addition, the Department is also proposing two evaporative purge tests at N.J.A.C. 7:27B-4.10 (see discussion below).

The two evaporative system integrity (pressure) tests will be used by public or private inspection facilities to evaluate the evaporative system for leaks. The first test, described at N.J.A.C. 7:27B-4.9(b), is the pressure test developed by the State in conjunction with a private contractor. The test is performed by pressurizing the evaporative system, from the fuel tank to the evaporative canister, with nitrogen or a functionally equivalent gas to 14 inches of water. The evaporative system is then monitored for a drop in pressure. Any pressure drop of six or more inches of water shall be considered an evaporative emission test failure. During the pressure test, the gas cap will be simultaneously pressurized and tested with procedures similar to those just described.

The second pressure test, described at N.J.A.C. 7:27B-4.9(c), is the one recommended by the EPA in its final rule on I/M program requirements at 40 CFR 51.357(a)(10). The EPA's evaporative pressure test requires that the system be pressurized from the evaporative canister to the fuel tank with nitrogen to 14 inches of water (plus or minus 0.5 inches) without exceeding 26 inches. The evaporative system is then sealed and monitored for pressure decay for a maximum of two minutes. After two minutes, the gas cap is loosened and the system is monitored for a sudden pressure drop, indicating that the fuel tank was pressurized.

N.J.A.C. 7:27B-4.10 Procedures for the evaporative purge test

The Department is proposing to add tests of each vehicle's evaporative purge system at N.J.A.C. 7:27B-4.10, as required by the EPA's rule on I/M program requirements at 40 CFR §51.357(a)(9).

Both of the two evaporative performance (purge) tests being proposed by the Department check whether captured fuel vapor is being properly removed from the canister and delivered to the engine during vehicle operation. The first test, at N.J.A.C. 7:27B-4.10(b), is conducted by introducing helium into the fuel tank during either of the proposed exhaust emission tests (that is, the IM240 test or the ASM5015/2500 RPM). The measurement of the helium concentration at the tailpipe is used to determine if the engine is purging vapors properly from the gasoline storage system. This purge test can be used in conjunction with either the ASM5015/2500 RPM exhaust test or an IM240 exhaust test, with or without use of the "fast-pass/fast-fail" algorithm.

The second purge test, described at N.J.A.C. 7:27B-4.10(c), is the one EPA recommended in its final rule on I/M program requirements at 40 CFR §51.357(a)(9). The EPA's purge test measures the total purge flow (in standard liters) occurring in the vehicle's evaporative system during the exhaust emission test driving cycle. The purge flow measurement system connects to the evaporative system in series between the canister and the engine.

A purge test is performed simultaneously with the exhaust emission test procedure. The EPA's "fast-pass/fast-fail" algorithm developed for its IM240 exhaust test includes purge standards which would allow a vehicle to pass or fail the purge test without completing the full test cycle. This is not a separate algorithm from the one used for the IM240 test, but is a piece of that algorithm that can only be used with the EPA-recommended purge test.

N.J.A.C. 7:27B-4.11 Procedure for on-board diagnostics testing

As required by the CAAA, the EPA has promulgated rules at 40 CFR §86 requiring manufacturers to equip new vehicles with on-board diagnostic (OBD) systems beginning with the 1994 model year. These advanced OBD systems, known as OBD II, monitor the performance of the vehicle's emission control equipment, fuel metering system, ignition system, and other equipment and operating parameters for the purpose of detecting malfunction or deterioration in performance that would be expected to cause a vehicle to fail to meet emission standards. When such problems are detected, a malfunction indicator lamp located in the dashboard of the vehicle is illuminated, instructing the vehicle driver to "Check Engine." A vehicle cannot pass emission inspection until proper service is conducted to correct the problem.

The EPA has indicated that it will promulgate rules which will establish OBD test procedures and which will direct states, as part of their I/M programs, to begin testing for OBD failures by using these procedures The Department, therefore, is reserving a section in the proposed rules at N.J.A.C. 7:27B-4.11 for OBD test procedures.

Social Impact

These proposed amendments and new rules will have a positive social impact. They are designed to aid the State in attaining and maintaining the NAAQS for CO and ozone by reducing the emission of air contaminants from motor vehicles through an approvable, Federally-mandated enhanced I/M program.

Though manufacturers of motor vehicles have progressively reduced the emissions of air contaminants from motor vehicles, vehicles continue to contribute 27 percent of the VOCs and 38 percent of the NO_x emissions (both of which contribute to the formation of ambient ozone), as well as 66 percent of the carbon monoxide released into New Jersey's air. Motor vehicles are also a major contributor to the toxics present in the atmosphere, such as benzene.

According to the 1990 base emission inventory developed by the Department during 1993, highway sources contribute 37.7 percent of the 1,511 tons of NO_x added daily to the atmosphere in New Jersey. NO_x cause irritation to the lungs, lower resistance to respiratory infections, and contribute to the development of emphysema, bronchitis, and pneumonia. NO_x also react chemically in the air to form nitric acid, which contributes to acid rain formation.

The 1990 base emission inventory also shows that for VOCs in New Jersey, highway sources contribute 26.7 percent of the daily total VOC emissions in New Jersey of 1,776 tons. Some VOCs, including benzene, formaldehyde and 1,3-butadiene, are classified as air toxics. They have been associated with the onset of cancer and other adverse health effects.

VOCs participate in photochemical reactions with NO_x to create ozone and other oxidants. Ground level ozone is a major public health problem in New Jersey. Studies have proven that ozone has severe and debilitating effects on lung capacity and can have detrimental effects on respiration. A series of EPA studies indicate that ozone exposures as low as 0.08 ppm, well below the NAAQS of 0.12 ppm, can impair lung function. Even at low levels, ozone can cause average humans to experience breathing difficulty, chest pains, coughing and irritation to the nose, throat and eyes. For individuals who already experience respiratory problems or who are predisposed to respiratory ailments, these symptoms can become much more severe, forcing those individuals to alter their lifestyles to avoid unnecessary exposure.

In addition, chronic ozone exposure studies performed on laboratory animals indicate that long-term exposure to ozone affects lung physiology and morphology. These studies suggest that humans exposed to ozone over prolonged periods of time can experience chronic respiratory injuries resulting in premature or accelerated aging of human lung tissue.

The implications of these studies are quite serious considering the fact that in 1991, New Jersey's air was categorized as "unhealthy" on 36 days. Twenty-six of these days were categorized "unhealthy" due to excessive ozone levels, that is, where the State was out of compliance with the NAAQS of 0.12 ppm. In the 1992 summer season, there were only nine exceedances of the NAAQS for ozone, but that decrease from the prior year has been attributed not to a significant reduction in VOC and NO_x emissions, but rather to an unusually cold, cloudy season, which did not provide conditions conducive to the photochemical reaction which results in ozone production. In 1993, New Jersey exceeded the NAAQS of ozone on 18 days.

Furthermore, New Jersey's air exceeded the ozone level of 0.08 ppm (the amount at which EPA's studies indicate that lung function may deteriorate) an average of 228.47 hours through the "ozone season" or summer months of 1991, 1,140 hours in the summer months of 1992 and 2,414 hours in the summer months of 1993. It is clear, therefore, that the ozone levels in New Jersey must be reduced in order to protect the health and welfare of the residents of the State.

The Department's 1990 base year inventory indicates that highway sources alone contribute 66.2 percent of the total CO in New Jersey of 4,459 tons/day. This poisonous gas interferes with the oxygen-carrying ability of the blood. Exposure to CO aggravates angina and other aspects of coronary heart disease and decreases exercise tolerance in persons with cardiovascular problems. In fetuses, infants, elderly persons, and individuals with respiratory diseases, elevated levels of CO are also a serious health risk.

These amendments and new rules will affect all New Jersey residents in some fashion. Overall, they will benefit the residents of New Jersey by providing them with cleaner air and thus a healthier environment.

According to current DMV registration data, there are approximately 4.8 million passenger vehicles registered to both individuals and businesses in New Jersey. Virtually all of these vehicles will be subject to the enhanced I/M program. As such, they will be better maintained, resulting in greater fuel economy and reduced emissions. The enhanced I/M program includes a more stringent exhaust emission test than are part of the current vehicle inspection program and additional evaporative emission control tests. Since vehicles will be subject to more advanced tests and more stringent standards, motorists may see an increase in repair costs. The emission malfunctions identified by the enhanced I/M program may be in addition to and less obvious than those currently detected, and may sometimes require more sophisticated service and equipment to correct.

Although the Department and the DMV are proposing measures to mitigate it, motorists may also experience the "ping-pong" effect. The EPA refers to the "ping-pong" effect as one of the possible problems associated with the IM240 test, with or without use of the "fast-pass/fast-fail" algorithm. Since repair technicians working on IM240 failures may not have access to IM240 test equipment because of its cost, they could perform repairs without the ability to duplicate the test for diagnostic feedback. This could result in a process whereby an initially failed vehicle is "repaired," that is, passes tests given at the repair facility, but fails reinspection at the test-only facility, thus requiring one or more return trips to the repair facility. This process could continue several times while the mechanic searches for the problem causing the failure, resulting in inconvenience and increased repair costs for the motorist.

The ASM5015/2500 RPM exhaust test is conducted with less costly test equipment which would be more affordable for repair facilities. This could reduce the occurrence of the "ping-pong" effect. However, since repair technicians currently use automotive analyzers and diagnostic equipment which are better able to interface with on-board diagnostic systems and identify emission component failures, they have an additional system of diagnostic feedback. Thus, the likelihood of the "ping-pong" effect occurring with the IM240 exhaust emission test would be limited to very elusive emission system malfunctions.

Use of either the "fast-pass/fast-fail" IM240 or the ASM5015/2500RPM represent changes with substantial impacts on the motorist and the repair industry. Specifically, the enhanced exhaust test, unlike the current exhaust test, will measure the level of NO_x emissions. It will also more precisely measure levels of HCs and CO emissions than does the current test. It is anticipated that more motorists will be required to make repairs on vehicles for emission-related defects that are not identifiable under the current program. It is the identification and correction of these defects, however, which will significantly reduce emissions and result in improved air quality.

Use of the proposed evaporative purge or pressure tests will also have significant impacts on the motoring public, since these tests are not currently conducted in New Jersey. The purge test will examine the vehicle's evaporative system for functional problems, while the pressure test will evaluate the evaporative system for leaks. Performance of either of these test could lead to an increased likelihood of inspection failure. Thus, as with the enhanced exhaust test, the purge and pressure tests could result in repairs not previously required. However, once again, it is the identification and correction of said emission-related defects that will result in significantly improved air quality.

The proposed addition of penalties at N.J.A.C. 7:27A-3.10 will facilate enforcement of the proposed prohibition of operating non-certified vehicles, leasing or offering for sale or lease of tampered vehicles, and selling or offering for sale emission control defeat devices. To the extent that

these penalties further the goals of the enhanced I/M program, they advance the positive social impact of the program as a whole, described herein.

The enhanced I/M program, as it was initially proposed by the Department in conjunction with the DMV, called for the separation of test and repair within the same facility. Under the previously proposed amendments and new rules, private inspection centers (PICs), of which there are approximately 3,900 licensed in New Jersey, would have been forced to choose between performing inspections only or performing repair and repair-related activities only. However, the EPA's final rule on I/M program requirements provides at 40 CFR 51.353 that enhanced I/M programs must be operated in a centralized test-only format, unless the state can demonstrate that a decentralized program is equally effective in achieving the enhanced I/M performance standard. The Department, in conjunction with the DMV, has developed an enhanced I/M program design that will allow New Jersey-licensed PICs to continue to perform test and repair activities without compromising air quality or the State's ability to achieve the enhanced I/M performance standard.

Allowing for a limited test-and-repair component of the enhanced I/M program has some positive social effects. This will clearly benefit those small businesses which would otherwise have been forced to give up some portion of their business in order to become either test-only or repair-only under a completely centralized enhanced I/M program. This in turn would have also made the inspection and/or repair process less convenient for the motoring public, who would have had fewer facilities from which to choose for testing and/or repairs and, more importantly, would have been required to use separate facilities for emission testing and repair. A more detailed discussion of the impacts on these PICs can be found in the Regulatory Flexibility Analysis below.

Economic Impact

The proposed amendments and new rules will result in both positive and negative economic impacts. While implementation of the amendments and rules will involve initial and associated costs for compliance, it will also result in improved air quality, thereby reducing the substantial costs to the State associated with air pollution. In addition, by complying with Federal air quality standards, the State will be able to avoid the significant adverse economic impact of Federal sanctions.

It is anticipated that a portion of the approximately 3,900 test-and-repair stations that currently perform 20 percent of the State's vehicle inspections will choose to continue operating as repair-only facilities and discontinue their inspection operations, both because of the greater cost of enhanced I/M test equipment and the limitation on test and repair within the same facility. This additional loss of PICs will result in the need for State inspection lane expansion, as discussed below, and will have an economic impact on those PICs opting to discontinue inspections, as is discussed more fully in the Regulatory Flexibility Analysis below.

Both because this limitation on PICs will shift many inspections to the centralized State lanes and because the enhanced test procedures will be of longer duration then they are at present, the DMV anticipates that adoption of the proposed enhanced I/M program will necessitate the modification and upgrading of at least 59 of its 86 inspection lanes. Upgrading the existing inspection lanes will assure an efficient inspection system providing convenient service to the motoring public of this State.

Concerns with the ability of the "fast-pass/fast-fail" IM240 test to achieve an acceptable throughput have led the DMV and the Department to develop a fallback measure to obtain the necessary throughput. The EPA had reported that the "fast-pass/fast-fail" IM240, in conjunction with the "fast-pass/fast-fail" purge test, would achieve a throughput of 20 vehicles per hour. However, as discussed above in the Summary, the DMV, using this test procedure in its experimental inspection lane in Wayne, New Jersey, has been unable to achieve this throughput. Although the EPA has attributed the State's inability to achieve the expected throughput to its inexperience with performing a transient emission test, the Department and the DMV believe this inability to be the fault of the test methodology itself. Accordingly, the centralized inspection centers will be allowed to "switch" from the IM240 exhaust emission test to the faster ASM5015/2500 RPM exhaust emissions test under certain specified conditions. The EPA has indicated that this would be an acceptable contingency measure.

The DMV intends to implement the enhanced I/M program based on a 15 vehicle per hour throughput. The provision of the "switch" will allow the State to attain or exceed this throughput without constructing new lanes. Thus, use of this switching mechanism will avoid an unacceptable increase in the initial capital costs and operating costs of the enhanced I/M program. In addition, inspection by PICs of certain vehicle model years that would otherwise be subject to testing at test-only facilities will also reduce the need for the construction of more centralized inspection lanes, thus reducing initial capital costs.

Although the DMV had initially estimated that implementation of the IM240 emission test would require $282 million in capital expenditures, implementation of the "fast-pass/fast-fail" IM240 would require a lower capital investment if the State can achieve the throughput of between 15 to 20 vehicles per hour promised by the EPA. In that case, the capital costs of the "fast-pass/fast-fail" IM240 program (with vehicles less than five years old inspected at PICs) is estimated to be between $74 and $108 million. There will be minimal additional cost for switching to the ASM5015/2500 RPM exhaust test. Cost to operate the centralized lanes (not including oversight costs) are estimated to be between $37 and $48 million annually.

Incorporated into the program's capital costs are the costs of each component of the proposed enhanced I/M program. These components include the evaporative pressure and purge testing equipment. The Department has estimated that the equipment costs of either of the alternative pressure tests being proposed by the Department would be approximately $500.00 per inspection lane. However, the equipment costs of the alternative purge tests vary significantly. The purge test developed by the State in conjunction with a private contractor requires the use of an inert gas measuring device and would the cost the State approximately $10,000 per inspection lane in initial capital expenditures. The EPA-recommended purge test will cost about $500.00 per inspection lane in initial capital expenditures.

Even though the EPA-recommended purge test has a lower initial capital investment than the State-developed purge test, overall it is more costly due to the time and labor needed for performing the test. The EPA-recommended purge test requires connection of the purge flow measurement system to the purge portion of the evaporative system nearest the evaporative canister. Since the location of the canister varies depending on vehicle manufacturer and model type, it may take a considerable amount of time for the inspector to locate the canister and connect the equipment. This would increase the overall time spent inspecting a vehicle and would reduce throughput. However, considering the lower initial capital expenditure, the EPA-recommended purge test would most likely be more cost effective for the PICs, which are not as concerned with throughput.

Another component of the enhanced I/M program that would be reflected in the program's capital costs is on-road testing. Currently, the State performs an idle test utilizing BAR84 equipment during roadside inspections. While the proposed on-road testing procedure would also use an idle test, the equipment used to perform this test would be upgraded to BAR90 analyzers. This equipment upgrade would cost approximately $6,000 per unit in initial capital costs.

The Department has modelled the environmental benefits for its program design using the EPA's MOBILE5a. The results of this modelling conducted by the Department yield the following mobile source emission reductions relative to a "no-I/M" scenario for the proposed program: 33.6 percent for VOCs in the year 2000, 14.9 percent for NO_x in the year 2000 and, in the year 2001, 34.4 percent for CO.

These percentages, applied to the estimated emission inventories for the year 2000, yield the following reductions in tons/day for the proposed program: 190 for VOCs, 60 for NO_x and, in the year 2001, 1,258 for CO.

The modelled emission reductions relative to the estimated capital and operating costs yield the following cost-effectveness ratios: $655.00 to $873.00/ton of VOC; $2,288 to $3,047/ton of NO_x; and $97.00 to $129.00/ton of CO. Based on its experience, the Department has determined that average stationary source reduction measures for VOCs are currently in the range of $3,000 to $6,000 per ton. The proposed enhanced I/M program is, therefore, significantly more cost-effective than these measures. Cost-effectiveness ratios for stationary source controls for NO_x and CO are comparable to those calculated for the enhanced I/M program.

Because the proposed enhanced I/M test procedures are more advanced than the current I/M test procedures, they can more accurately and selectively determine which vehicles are in need of repair. Under the present I/M program in New Jersey, the failure rate for emissions is 11 to 15 percent. It is anticipated by the EPA that the enhanced I/M program will increase the failure rate to approximately 30 percent. Emission failures under the enhanced I/M program may be more difficult to diagnose given the greater sensitivity and more stringent standards

of the proposed tests. Defects resulting in enhanced I/M emission test failures will require a higher level of mechanic skill to locate and correct the problem, resulting in increased parts and labor costs.

The EPA has estimated the costs of repairing vehicles which fail the IM240 test. (See 57 Fed. Reg. 52963-64, Nov. 5, 1993.) The estimated cost to fix a transient test failure that would also fail the test currently employed in New Jersey is $75.00. The average cost to repair vehicles failing the transient test that would not have failed the current test is estimated to be $150.00. The overall average repair cost for transient failures is estimated to be $120.00. Average repair costs for evaporative system pressure and purge test failures are estimated to be $38.00 and $70.00, respectively. Although NO_x repairs cannot be accurately estimated, EPA has projected that repairs for NO_x failures would cost approximately $100.00 per vehicle. Since the Department is proposing exhaust emission testing substantially similar to the EPA's, it expects the repair costs for vehicles failing the exhaust test to be identical to the EPA's estimates. Even though these repair costs are significantly greater than those incurred under the present inspection program, it should be noted that the anticipated failure rate is 30 percent and that it is highly unlikely that any particular vehicle that fails inspection will require all three types of repairs. Also, some newer vehicles may be repaired at no charge to the owner, due to Federally-regulated emission control warranty coverage provided by the manufacturer.

In an attempt to alleviate some of the increased costs to the consumer resulting from the proposed enhanced I/M program, the Department is proposing to establish a waiver program, in accordance with 40 CFR §51.360. As discussed in the Summary discussion of N.J.A.C. 7:27-15.10, motorists may qualify, under limited circumstances, for either a cost waiver. Either of these waivers would exempt a vehicle from the requirements of the Department's rules, specifically N.J.A.C. 7:27-15.5(e), and the DMV's inspection requirements under Title 39 and N.J.A.C. 13:40-43.2 for one inspection cycle. The implementation of this section should provide a smoother transition to the proposed new enhanced I/M program without significantly reducing the air quality benefits expected from the program.

As previously mentioned in the Social Impact statement above, the EPA has identified the "ping-pong" effect as one of the possible problems resulting from repair facilities' anticipated lack of adequate diagnostic feedback. Although the Department believes that the likelihood of this happening would be limited to elusive emission system malfunctions, it agrees that the "ping-pong" effect is a potential problem which includes an adverse economic impact on motorists necessitating mitigating tactics.

To help prepare the motor vehicle repair industry for the proposed new emission tests, the New Jersey Department of Education (DOEd) is proposing to expand its technician training curriculum to include the new inspection procedures being proposed by the Department. DOEd plans to update its existing Automotive Technician instructional programs to meet the new requirements facing the auto service industry in four phases: (1) curriculum development; (2) funding of equipment and facilities for the model sites; (3) implementation of the curriculum; and (4) training of current and future technicians, evaluation of the program and updating of instruction.

In addition, the DOEd has submitted a grant proposal to the EPA for Project CLEEN (Competencies for Learning Environmental Education Now). If funded, the program will be developed by an intergovernmental task force which includes the DOEd, the Department, the Northeast Curriculum Coordinating Center (NE) for Vocational Technical Education, the NJ Technical Assistance Program (NJTAP) for Industrial Pollution Prevention, NJ Institute of Technology (NJIT) and local education agencies. This program would be designed to begin the infusion of pollution prevention education in all occupational training programs, including education concerning the enhanced I/M program. The Department, in conjunction with the DOEd, believes that a more comprehensive, advanced education program, promoted by the above mentioned programs, would provide technicians with a broader understanding of the emission-related malfunctions that could occur in order to further limit the occurrence of "ping-pong" incidents.

To better monitor and control the repair industry, the DMV is proposing to license repair facilities. This proposed program will include monitoring the performance of each repair facility. One method for monitoring these facilities will be a "report card" system, whereby repair facilities will be graded according to their performance and ranked accordingly. These grades will be made available to the public in an effort to both encourage repair facility participation in technician education and keep the public informed. Such performance monitoring is mandatory under EPA's enhanced I/M rules, 40 CFR §51.369(b), and will help to ensure that motorists are being provided with objective and effective repairs. In addition, the DMV will be providing a hotline service to assist repair technicians with specific repair problems, as required at 40 CFR §51.369(a)(2). Since these portions of the I/M program will be administered by the DMV, the reader should refer to DMV's pre-proposal of N.J.A.C. 13:20-43 for more information concerning the licensing and monitoring of repair facilities, as well as the administration of a technical hotline service.

Implementation of the enhanced I/M program will have an impact on State government resources. Most of this impact will fall on the DMV since it is the primary operational agency for the enhanced I/M program. See the DMV's pre-proposal of N.J.A.C. 13:20-43 at 25 N.J.R. 3418(a), August 2, 1993.

However, the Department's resources will also be impacted by the enhanced I/M program. Currently, the Department has three staff members working on regulatory development and program oversight. In addition, there are five Department employees conducting quality assurance auditing. The Department anticipates that implementation of the proposed enhanced I/M program will require two additional staff members for program oversight and one to two more employees for quality assurance auditing.

Salaries for the Department staff are funded in part by a grant under Section 105 of the CAA. This grant is intended to assist states in implementing the provisions of CAA. Additional funds are obtained from permitting fees and fines from violations of the Department's air pollution regulations.

A positive economic impact of the proposed enhanced I/M program will result from repairs made to vehicles that have failed and are effectively repaired. The resultant fuel economy benefits will help to offset the cost of repairs to motor vehicle owners and operators. Average fuel economy improvements of 6.1 percent for repair of pressure test failures and 5.7 percent for repair of purge test failures have been observed by the EPA. The EPA also reports that the fuel economy of vehicles that failed the IM240 test improved by 12.6 percent as a result of repairs. It should also be noted that these fuel economy improvements generally continue beyond the year of the test.

The proposed amendments and new rules will have positive economic effects on the repair industry in the form of increased business generated by the higher failure rate expected from the enhanced I/M program. The anticipated expansion of the service industry will result in increased employment and will help to offset potential financial loss to the repair industry from the limitation of performing test and repair activities at a single facility.

The amendments and new rules will also have a substantial, important, and indirect benefit by decreasing health costs to the general public. Health care costs for air pollution-related illnesses in the United States are estimated to be on the order of $50 billion per year. In addition, the American Lung Association estimates that, nationally, 182 million people face health threats from ground-level ozone alone. By decreasing the public's exposure to ozone, CO, and air toxics, these amendments and new rules will lessen these health care costs.

Air pollutants also have a direct adverse effect on vegetation, livestock, and certain materials, such as rubber, glass, etc. Although economic losses due to air pollution damage in these areas are difficult to quantify (since it is difficult to distinguish between natural deterioration and that which is caused by air pollutants), past estimates have indicated that losses from material damage alone have exceeded $4 billion annually nationwide. Godish, Thad. *Air Quality* (Chelsea, Michigan: Lewis Publishers, Inc., 1991), p.207. This proposal, by reducing air pollutants, should substantially reduce the adverse economic effects on vegetation, livestock, and other property.

The proposed addition of penalties at N.J.A.C. 7:27A-3.10 will facilate enforcement of the proposed prohibition of operating non-certified vehicles, leasing or offering for sale or lease of tampered vehicles, and selling or offering for sale emission control defeat devices. To the extent that these penalties further the goals of the enhanced I/M program, they advance the positive economic impact of the program as a whole, described herein.

In an attempt to mitigate driver inconvenience, the program provides for a biennial (every other year) inspection frequency beginning with the second year of the vehicle's life. EPA modelling demonstrates that biennial programs would have minimal adverse effects on the environmental benefit gained from the enhanced I/M program and will help to diminish costs and encourage consumer acceptance.

Environmental Impact

The implementation of these new rules and amendments to N.J.A.C. 7:27-15 and 7:27B-4 will have a positive impact on the environment by reducing the emissions of VOCs and NO_x, thereby reducing the formation of ground-level ozone. Ground-level ozone's primary impact is upon human health and well-being. In addition, these amendments will also reduce the emissions of other harmful pollutants, such as CO and carbon dioxide. These effects are discussed at length in the Social Impact statement of this proposal.

In addition to human health effects, studies have shown that increasing ozone levels damage foliage. One of the earliest and most obvious manifestations of ozone impact on the environment is this type of damage to sensitive plants. Subsequent effects include reduced plant growth and decreased crop yield. A reduction in ambient ozone concentrations will mitigate damage to foliage, fruits, vegetables and grain.

In addition, decreased ozone levels will result in less degradation of various man-made materials, such as rubber, plastics, dyes and paints. This degradation is caused by the oxidizing properties of ozone. However, if the photochemical production of ground-level ozone can be limited, as it will be with the implementation of the proposed amendments, this degradation will be significantly reduced.

Although ozone is well-known for its damaging effects on the environment, NO_x, one of the reactants in the production of ozone, can also independently cause significant environmental degradation. NO_x are the primary constituents involved in the deposition of toxics, commonly referred to as acid rain, into lakes and coastal waters. Acid rain damages plants and trees, and injures aquatic life by acidifying lakes and streams. The proposed new emission tests will result in a decrease of emissions of NO_x into the atmosphere and benefit the environment of New Jersey.

As discussed previously under the Economic Impact section, the Department and the EPA have modelled the emission reduction benefits of the proposed program design described in the Summary section above over a no-I/M scenario. The results of these modelling exercises are listed in Tables 1 through 4 below.

TABLE 1

MOBILE5a Emission Factors and Emission Reductions for New Jersey Proposed Program in the Year 2000

	VOC		NO_x	
	g/mi	reduction	g/mi	reduction
No I/M	3.139	—	2.243	—
Current I/M	2.886	1.8%	2.189	2.4%
Enhanced Performance Standard	2.102	33.0%	1.952	13.0%
NJ Proposed Program	2.036	35.1%	1.927	14.1%

TABLE 2

MOBILE5a Emission Factors and Emission Reductions for New Jersey Proposed Program in the Year 2001

	CO	
	g/mi	reduction
No I/M	20.08	—
Current I/M	17.13	14.7%
Enhanced Performance Standard	13.07	34.9%
NJ Proposed Program	12.67	36.9%

TABLE 3

Estimated Reductions in tons/day for VOC and NO_x in the Year 2000

	VOC reduction (tons/day)	NO_x reduction (tons/day)
Current I/M	46	10
Enhanced Performance Standard	187	52
NJ Proposed Program	199	57

TABLE 4

Estimated Reductions in tons/day for CO in the Year 2001

	CO reduction (tons/day)
Current I/M	537
Enhanced Performance Standard	1,275
NJ Proposed Program	1,348

Tables 1 through 4 represent the results of modelling using the EPA's MOBILE5a. Tables 1 and 2 compare pollutant reductions realized under the proposed enhanced I/M program to that of the EPA's model program performance standard. All of the estimated reductions are calculated from a no-I/M scenario. The current I/M scenario gives a perspective on the necessity of an enhanced I/M program.

VOCs and NO_x are precursors to ozone formation. For this reason, efforts to attain and maintain the NAAQS for ozone have focused on reducing VOC and NO_x emissions. In 1990, VOC emissions in New Jersey totalled 1,776 tons per summer weekday with 474 tons attributed to emissions from all mobile sources, not just exhaust emissions. New Jersey's proposed program design is expected to reduce VOC emissions by 190 tons per day in the year 2000. In 1990, NO_x emissions in New Jersey totalled 1,511 tons per summer weekday with 570 tons per summer weekday attributed to emissions from all mobile sources. The proposed program is expected to reduce NO_x emissions by 60 tons per day.

CO is generally a localized wintertime pollutant, elevated levels of which are related to colder temperatures and congested traffic. In 1990, CO emissions in New Jersey totalled 4,450 tons per winter weekday, with 2,952 tons per winter weekday attributed to all mobile sources. The proposed program is expected to reduce CO emissions by 1,258 tons per day in the year 2001.

It is anticipated that mobile source emission reductions from the existing New Jersey I/M program will be the following for the enhanced I/M program: for the year 2000, 27.8 percent for VOCs and 12.7 percent for NO_x, and, for the year 2001, 23.1 percent for CO.

As stated previously, the Department is proposing two sets of evaporative emission tests—those recommended by the EPA in its final rule on I/M program requirements and those developed by the State. The Department and the DMV believe that the State-developed evaporative tests are more effective than those recommended by the EPA. Environmental Systems Products (ESP) and the Radian Corporation each performed comparison tests on the EPA-recommended and the State-developed evaporative tests to evaluate their relative effectiveness. "Feasibility and Cost of Enhancements to the Illinois Vehicle Emission Test Program", Radian Corporation, 11th September 1992. "Evaluation of Alternative Pressure and Purge Techniques", Environmental Systems Products, 20th January 1993.

Use of the EPA-recommended pressure test showed that 20 percent of the vehicles had evaporative canisters which were not readily accessible and therefore could not be tested in under 10 minutes. Thus, this test is only feasible on approximately 80 percent of the in-use fleet. Although use of the State-developed pressure test also requires access to the vapor line, it requires that, in most cases, the line only be clamped rather than completely disconnected, as with the EPA-recommended pressure test. Therefore, on some vehicles, the vapor lines could be clamped off even though the canister itself was unreachable. The State-developed pressure test can effectively test about 92 percent of the in-use fleet and do so within a shorter timeframe. In addition, ESP studies have indicated that the State-developed pressure test has the advantage of pressurizing the gas tank through the large filler neck opening rather than through the vapor line from the canister. This vapor line from the canister to the gas tank frequently restricts vapor flow from the canister to the gas tank, making pressurization of the gas tank from the canister difficult or impossible.

In the ESP/Radian testing of EPA-recommended purge test, findings were similar to those for the EPA-recommended pressure test, that is 20 percent of the vehicles had canisters which were not readily accessible and which could not be tested in under 10 minutes. In contrast, the helium purge technique used in the State-developed purge test is feasible for any vehicle which can receive an IM240 test and have helium gas supplied through the gas tank. In performing tests on these two purge procedures, ESP has not encountered a vehicle which could not be testing using the State-developed methodology. The assumption, therefore, is that 99 percent of the in-use fleet may be tested using the State-developed purge test.

The ESP/Radian study of the evaporative emission tests demonstrate that the State-developed evaporative tests can be performed on more vehicles. Use of these tests result in fewer vehicles not receiving the evaporative tests and, therefore, will have a positive environmental impact and will benefit air quality. However, as stated in the Economic Impact statement above, the capital cost of the equipment used to perform the EPA-recommended evaporative tests is comparable to or less than that of the State-developed evaporative tests. Therefore, because of the differential in equipment costs, the PICs may elect to use the EPA-recommended evaporative test procedures.

The proposed addition of penalties at N.J.A.C. 7:27A-3.10 will facilitate enforcement of the proposed prohibition of operating non-

certified vehicles, leasing or offering for sale or lease of tampered vehicles, and selling or offering for sale emission control defeat devices. To the extent that these penalties further the goals of the enhanced I/M program, they advance the positive environmental impact of the program as a whole, described herein.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Department has determined that the proposed amendments and new rules will not impose additional reporting or recordkeeping requirements on small businesses (as defined in the Regulatory Flexibility Act). It will, however, impose compliance requirements on small businesses, in that such businesses will be required (much as they are currently required under the existing rule) to undertake the inspection and maintenance of motor vehicles that they own. The difference in compliance is that the amendments and new rules provide for the application of stricter emissions standards and the use of more sophisticated equipment and test procedures designed to identify and fail high emitters, some of which are currently not being identified and repaired. The Department believes that the majority of New Jersey's small businesses (those with fewer than 100 employees) will be affected by the amendments and new rules because most own gasoline-fueled motor vehicles, which will require a higher level of maintenance and may require more substantive repairs to obtain compliance with New Jersey's enhanced standards.

The anticipated adverse economic impact that this requirement would have on such businesses relates directly to the increased cost of motor vehicle inspection and the additional and more costly repairs to those vehicles which might have otherwise passed inspection and not have been required to have such repairs. As is discussed in the Economic Impact statement of this proposal, the overall average repair cost for those motor vehicles failing the enhanced I/M test procedure, predicted to be 30 percent of those tested, would be unlikely to exceed $300.00 per vehicle.

The resultant fuel economy benefits would, at least partially, and in some cases, even more than offset the cost of repairs. The EPA reports that vehicles that failed the IM240 test were found to exhibit a fuel economy improvement of 12.6 percent as a result of repairs. These fuel economy improvements generally continue beyond the year of the test. The resultant health benefits and reduction in property losses from the improvement in air quality should also, at least partially, offset these anticipated costs to small businesses.

In developing an enhanced I/M program for New Jersey, the Department has balanced the need to protect human health and the environment against any anticipated negative economic impact. As a result, it makes no allowances nor exceptions for small businesses. To do otherwise would have defeated the purpose of the program, as it would permit the continued operation of unrepaired high emitters on New Jersey's roads.

In addition, there may be a significant impact on a substantial number of small businesses that own and operate private inspection centers (PICs) in New Jersey. While the amendments and new rules are not directly responsible for this impact, it is discussed here briefly, as it results from implementation of the proposed enhanced I/M program of which these proposed rule amendments are a significant component. New Jersey's existing hybrid I/M system includes approximately 3,900 PICs, all of which perform both testing and repair services and most of which are small businesses. Regulatory authority regarding the administration of PICs is vested with the DMV. For more information concerning the enhanced I/M program's impacts on PICs, refer to the DMV's pre-proposal draft of N.J.A.C. 13:20-43 at 25 N.J.R. 3418(a), August 2, 1993.

The proposed enhanced I/M program will authorize PICs to continue as test-and-repair facilities only for a limited number and category of motor vehicles. As discussed in the Social Impact statement above, the EPA's final rule on I/M program requirements calls for a centralized test-only format, unless a state can demonstrate that a decentralized program would prove equally effective at achieving the enhanced I/M performance standard. 40 CFR §51.353. Because the approximately 3,900 PICs represent a significant portion of New Jersey's business community, the Department, in conjunction with the DMV, is concerned that limiting these small businesses to test or repair would have too severe a negative impact on the State's economy. Aside from its impact of these businesses, the inevitable loss of a significant number of these facilities as PICs would also result in additional program capital costs, as the State would be forced to construct new lanes at its centralized stations to inspect those vehicles which had previously been inspected at a PIC.

As stated previously, the EPA, in its final rule on I/M program requirements, has provided that states may operate a decentralized network if those states can demonstrate that a decentralized program is equally effective in achieving the enhanced I/M performance standard as a centralized test-only network. The Department, in conjunction with the DMV, believes that decentralized test-and-repair facilities provide added convenience to the motoring public primarily by allowing a vehicle to be tested, repaired and retested all at one location. For this reason, the Department and the DMV have sought to utilize the flexibility provided in the EPA's final rule to gain maximum participation of test-and-repair facilities in New Jersey's enhanced I/M program while continuing to meet the EPA's performance standard. Computer modelling using the EPA's mobile source emission factor model, MOBILE5a, has demonstrated that the maximum permissible test-and-repair participation achievable under the EPA's performance standard is limited to vehicles less than five years old.

This limited test-and-repair program will minimize the negative economic impact on small business in New Jersey without compromising air quality. In developing these rule amendments, the Department believes that it has successfully balanced the need to protect human health and the environment against the economic impact of the amendments as proposed.

The limitation of PIC participation in the inspection program may cause some PICs to give up the inspection portion of their business entirely, as it would no longer be as profitable. Facilities choosing to continue performing inspections can expect to see an increase in equipment costs. The equipment required for inspections under the proposed enhanced I/M program is more expensive than that currently in use. The Department estimates the cost of the enhanced I/M equipment to be approximately $25,000 to $30,000 per lane for the ASM5015 exhaust test and under $100,000 for the "fast-pass/fast-fail" IM240 exhaust test. In both case, the increased cost of equipment will be passed on to those consumers who choose to have their vehicles inspected at a private inspection center. PICs are permitted to charge up to one half of their hourly labor rate for an inspection, which is, on the average, $17.00 per inspection. The Department believes that this average may increase, in part to cover the increased cost to the PICs to operate the program.

The EPA projects, however, that any losses to the small business community would be offset by an increase in repair business generated by the enhanced I/M program. The repair industry would see a marked increase in business, since the new, technologically superior, enhanced inspection tests will detect marginal polluters that would previously have passed inspection and not required repairs. These vehicles will now have to be repaired, resulting in an increased volume of repair business and a need for additional mechanics. Also, the greater sophistication and complexity of the new enhanced I/M testing procedure would require more inspectors per lane than are currently needed. On a national basis, EPA estimated that three or four inspectors will be needed in each lane to perform emission testing compared to the one or two inspectors that are currently employed per lane in today's high volume systems. Additional costs of compliance will be incurred by PICs as a result of increased recordkeeping and reporting requirements imposed by the DMV's licensing and quality assurance regulations. For more information on these requirements, see DMV's pre-proposal of N.J.A.C. 13:20-43 at 25 N.J.R. 3418(a), August 2, 1993.

In addition to the direct increases in business growth that the new enhanced I/M program will provide, other employment opportunities will arise as an indirect result of the implementation of the proposed enhanced I/M program. In order to accommodate the new test equipment the State will have to upgrade existing State inspection centers. It will also have to construct new inspection centers and add lanes to existing centers to avoid lengthy waits resulting from an anticipated decrease in lane throughput. This will provide work for both the construction and manufacturing industries, both of which are comprised largely of small businesses. Overall, the EPA estimates that an enhanced I/M program will result in between 3,600 and 11,600 additional jobs nationwide, directly or indirectly related to testing and repair of motor vehicles as a result of the improved program.

This does not mean, however, that the implementation of this proposed enhanced I/M program will result in an overall net increase in employment in New Jersey. Resources allocated to testing and repair services may have otherwise been spent on other goods and services in the economy. Thus, it may be that other sectors of the economy may

incur employment losses. This shift in business opportunities should result in an equilibrium which will allow small businesses to continue operations in somewhat different capacities.

The Department also recognizes that several of the provisions in the proposal addressing emission control device tampering and other enforcement related topics may cause difficulties for some small businesses in the State. Particularly, the prohibition against the sale of emission control defeat devices will likely impact many dealers and installers of high performance aftermarket components in New Jersey who sell these devices currently. Clearly, to make exceptions for any such small businesses would defeat the purposes of the rules.

The proposed penalties to be imposed for the lease, or offer for sale or lease, of tampered vehicles would likely impact a number of car dealers engaging in these prohibited activities. In a like manner, the proposed penalties to be imposed for sale or offer for sale of emission control defeat devices would likely impact many manufacturers and installers of high performance aftermarket components in New Jersey. Clearly, however, to make exceptions for any such small businesses would defeat the purpose of these amendments and new rules.

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

SUBCHAPTER 15. CONTROL AND PROHIBITION OF AIR POLLUTION FROM GASOLINE-FUELED MOTOR VEHICLES

7:27-15.1 Definitions

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

"Air contaminant" means any substance, other than water or distillates of air, present in the atmosphere as solid particles, liquid particles, vapors or gases.

["Approved exhaust gas analytical system" means a device for sensing the amount of air contaminants in the exhaust emissions of a motor vehicle. For purposes of this subchapter, this shall mean analyzing devices of the nondispersive infrared type sensitized to measure carbon monoxide at the 4.74 micron band expressed as percent carbon monoxide in air and to measure hydrocarbons as hexane at the 3.41 micron band expressed as parts per million of hydrocarbons (hexane) in air. The device shall be approved by the Department as one which is in accordance with specifications contained in "Specifications For Exhaust Gas Analytical System For Use by New Jersey Division of Motor Vehicles Private Inspection Centers (PIC)" or "Specifications For Exhaust Gas Analytical System For Use by New Jersey Division of Motor Vehicles Operated Official Inspection Stations" and shall be used in accordance with the manufacturer's recommended procedures for calibration and maintenance.]

"California Air Resources Board (CARB)" means the agency of the State of California established and empowered to regulate sources of air contaminant emissions, including motor vehicles, pursuant to California Health & Safety Code, Sections 39500 et seq.

"Carbon monoxide (CO)" means a colorless, odorless, tasteless gas at standard conditions having a molecular composition of one carbon atom and one oxygen atom.

"Certified configuration" means a vehicle-engine-chassis design for LDGVs and LDGTs or an engine design for HDGVs certified by either of the following agencies as meeting the applicable emission standards for motor vehicles manufactured in a given model year:

1. EPA for model year 1968 or for a more recent model year; or

2. CARB for model year 1966 or for a more recent model year.

"Consumer Price Index (CPI)" means, for any calendar year, the annual average Consumer Price Index for all-urban consumers published by the United States Department of Labor, as of the close of the 12-month period ending on August 31 of each calendar year.

...

"Element of design" means any automotive part or system on a motor vehicle that is subject to the federal emission standards at 40 CFR Part 86 or California emission standards at California Code of Regulations Title 13 which:

1. Is included in the motor vehicle's certified configuration; and

2. Could affect the emission of any regulated air contaminant from the motor vehicle.

...

"EPA" means the United States Environmental Protection Agency.

"EPA Memorandum 1A" means the memorandum dated June 25, 1974, and issued by the EPA's Office of Enforcement and General Counsel, which sets forth the EPA's interim tampering enforcement policy. This term also includes any revisions to the policy set forth in the June 25, 1974 memorandum that are subsequently issued by the EPA. A copy of this EPA memorandum has been filed with the Office of Administrative Law and may be obtained from the Bureau of Transportation Control in the Department.

...

"G/mi" means grams per mile.

...

"Gasoline-fueled" means powered by a hydrocarbon fuel other than diesel fuel, including, but not limited to, gasoline, natural gas, liquified petroleum gas, and propane, and also powered by alcohol fuels, hydrocarbon-alcohol fuel blends and hydrogen.

["Gasoline-fueled motor vehicle" means any motor vehicle equipped to be powered by a hydrocarbon fuel other than diesel fuel, but including alcohol fuels and hydrocarbon-alcohol fuel blends.]

"Gross vehicle weight rating (GVWR)" means the value specified by the manufacturer as the maximum loaded weight of a single or combination vehicle.

"Heavy-duty [motor] **gasoline-fueled** vehicle (HDGV)" means [any] **a gasoline-fueled** motor vehicle **that has a GVWR of more than 8,500 pounds and that is** designed primarily for transportation of persons or property [and registered as exceeding 6,000 pounds gross weight].

...

"Light-duty gasoline-fueled vehicle (LDGV)" means a gasoline-fueled motor vehicle that has a GVWR of 8,500 pounds or less, is designed primarily for use as a passenger car or is a passenger car derivative and is capable of seating 12 or fewer passengers.

"Light-duty gasoline-fueled truck (LDGT)" means a gasoline-fueled motor vehicle that has a GVWR of 8,500 pounds or less, a vehicle curb weight of 6,000 pounds or less, and a basic frontal area of 45 square feet or less, and that is:

1. Designed primarily for the transportation of property or more than 12 passengers; or

2. Available with special features enabling off-street or off-highway operation and use.

"Light-duty gasoline-fueled truck 1 (LDGT1)" means a light-duty gasoline-fueled truck with a GVWR of 6,000 pounds or less.

"Light-duty gasoline-fueled truck 2 (LDGT2)" means a light-duty gasoline-fueled truck with a GVWR of more than 6,000 pounds.

["Light-duty motor vehicle" means any motor vehicle designed primarily for transportation of persons or property and registered at 6,000 pounds gross weight or less.]

"Loaded vehicle weight (LVW)" means the vehicle curb weight plus 300 pounds.

"Model year [of vehicle]" means**, with respect to a motor vehicle,** the [production period of new motor vehicles or new motor vehicle engines designated by the calendar year in which such period ends. If the manufacturer does not designate a production period, the model year with respect to such vehicles or engines shall mean the 12 month period beginning January of the year in which production begins.] **year in which the motor vehicle is considered to have been manufactured. If the manufacturer establishes an annual production period, designation of the year shall be based on the annual production period during which the manufacturer begins production of the motor vehicle. When such annual production period falls within one calendar year, the model year attributed to the motor vehicle shall be that calendar year. When such annual production period continues from one calendar year into the next, the model**

year attributed to the motor vehicle shall be the latter calendar year (for example, a motor vehicle produced in an annual production period that continues from 1993 to 1994 shall be considered as being produced in the 1994 model year). If the manufacturer establishes no annual production period, a motor vehicle's model year shall be the calendar year in which the manufacturer begins production of that motor vehicle. If a motor vehicle is manufactured in two or more stages, the model year of such a motor vehicle shall be based on the date of completion of the chassis.

"Motor vehicle emission testing equipment" means equipment in accordance with specifications contained in N.J.A.C. 7:27B, Appendix 7 ("Specifications For Motor Vehicle Emission Testing Equipment For Use in the New Jersey Enhanced Inspection and Maintenance Program"). The equipment shall include all devices used for performing a motor vehicle inspection, including, but not limited to, exhaust gas analyzers, evaporative pressure testing apparatus, evaporative purge testing apparatus, dynamometers, computers and related software.

...

"New motor vehicle" means a newly-manufactured motor vehicle [registered in New Jersey], prior to its delivery to the ultimate purchaser.

"Oxides of nitrogen (NO_x)" means all the oxides of nitrogen including, but not limited to, nitric oxide and nitrogen dioxide, except nitrous oxide (N_2O).

"Person" means **any individual or entity and shall include, without limitation,** corporations, companies, associations, societies, firms, partnerships, and joint stock companies, as well as individuals, and shall also include**, without limitation,** all political subdivisions of **the United States, foreign nations,** this State**, any foreign states,** or any agencies or instrumentalities thereof.

...

"Professional repair technician" means a technician professionally engaged in motor vehicle repair, who is also:

1. Employed by a business whose purpose is motor vehicle repair; or

2. In possession of nationally recognized certification for emission-related diagnosis and repair.

"Quasi-public property" means any property that, although under private ownership or control, is essentially public in nature and to which the public has access. This term shall include, but shall not be limited to, the New Jersey Turnpike, the Garden State Parkway, shopping mall roadways and parking lots, private business roadways and parking lots, private access roads and residential driveways and parking lots.

"RPM" means revolutions per minute.

...

"Tier 1 Standards" means standards for LDGTs and LDGVs of model years 1994 and later, prescribed at section 202(g) of the Clean Air Act, 42 U.S.C.A. 7521(g).

...

"Vehicle curb weight" means the actual weight of a motor vehicle in operational status or the weight given by the manufacturer for such a motor vehicle. Such weight shall include the weight of all standard equipment, of the fuel at nominal tank capacity, and of optional equipment computed in accordance with 40 CFR 86.082-24. This term, with respect to an incomplete light-duty gasoline truck, shall be the weight given by the manufacturer for such a truck.

7:27-15.2 Applicability

(a) Except as provided in (b) and (c) below, this subchapter applies to all light-duty and heavy-duty gasoline-fueled motor vehicles, including, but not limited to, motor vehicles fueled with gasoline, alcohol, gasoline-alcohol blends, natural gas, liquified petroleum gas, propane and hydrogen.

(b) This subchapter does not apply to motor vehicles operated solely on diesel fuel.

(c) This subchapter does not apply to motorcycles.

7:27-[15.2 Public] **15.3 General public** highway standard

(a) No person shall cause, suffer, allow or permit the operation of any gasoline-fueled motor vehicle upon the public **roads, streets** or highways of the State **or any public or quasi-public property in the State** if the vehicle emits visible smoke in the exhaust emissions or in the crankcase emissions for a period in excess of three consecutive seconds.

(b) No person shall cause, suffer, allow or permit the operation of any gasoline-fueled motor vehicle upon the public **roads, streets, or** highways of the State**, or any public or quasi-public property in the State,** if the vehicle emits hydrocarbons (HC) [or], carbon monoxide (CO)**, or oxides of nitrogen (NO_x)** in the exhaust emissions in excess of **any applicable** standards [as] set forth [in Table 1 when measured using an approved exhaust gas analytical system and the inspection test procedure established at N.J.A.C. 7:27B-4.5] **at N.J.A.C. 7:27- 15.6(b).**

(c) No person shall cause, suffer, allow or permit the operation of any gasoline-fueled motor vehicle upon the public roads, streets or highways of the State or any public or quasi-public property in the State if the motor vehicle does not meet all motor vehicle inspection testing requirements at N.J.A.C. 7:27-15.5 unless the motor vehicle has been issued a waiver in accordance with N.J.A.C. 7:27-15.10.

(d) No person shall cause, suffer, allow or permit the operation of any gasoline-fueled motor vehicle upon the public roads, streets or highways of the State or any public or quasi-public property in the State if the motor vehicle is not certified by either of the following agencies as meeting the applicable emission standards for motor vehicles manufactured in the model years listed below:

1. EPA for model years 1968 and later; or

2. CARB for model years 1966 and later.

7:27-[15.3]**15.4** New motor vehicle dealer [inspection compliance standard] **inspections**

(a) (No change.)

(b) Whenever emission specifications are not prescribed, the inspection standards as set forth in N.J.A.C. 7:27-[15.4(b)]**15.6(b)** shall apply to such new motor vehicles.

7:27-15.5 Motor vehicle inspection testing

(a) A motor vehicle subject to this subchapter and to a motor vehicle inspection pursuant to N.J.S.A. 39:8 shall be periodically inspected in accordance with this section.

(b) No motor vehicle shall be deemed to have passed a motor vehicle emission inspection unless it passes all of the tests that constitute the emission inspection.

(c) The owner of a motor vehicle subject to motor vehicle inspection requirements pursuant to N.J.S.A. 39:8 shall have the inspections performed at an official test-only inspection station operated by, or under contract with, the Division of Motor Vehicles, except that motor vehicles fewer than five model years old may be inspected at a Private Inspection Center licensed by the Division of Motor Vehicles.

(d) The owner of any motor vehicle subject to the motor vehicle inspection requirement at N.J.S.A. 39:8 shall have the motor vehicle inspected at least once every two years. In addition, in accordance with its procedures, the Division of Motor Vehicles may inspect motor vehicles more frequently.

(e) Any motor vehicle inspection test conducted pursuant to N.J.S.A. 39:8 shall include the following:

1. A visible smoke test conducted in accordance with N.J.A.C. 7:27B-4.5(a);

2. An exhaust emission test utilizing motor vehicle emission testing equipment approved by the Department and conducted in accordance with (h) below;

3. When inspected at a Private Inspection Center licensed by the Division of Motor Vehicles, all LDGVs and LDGTs shall be subject to an emission control apparatus compliance examination conducted in accordance with N.J.A.C. 7:27B-4.8;

4. All post-1974 model year LDGVs and LDGTs originally equipped with an evaporative emission control system shall be subject to an evaporative pressure test utilizing motor vehicle emission testing equipment approved by the Department and conducted in accordance with N.J.A.C. 7:27B-4.9;

5. All post-1974 model year LDGVs and LDGTs originally equipped with an evaporative emission control system that are subject to the exhaust emission testing requirement in (e)2 above through use of the ASM5015 test or the IM240 test shall be subject to an evaporative purge test utilizing motor vehicle emission testing equipment approved by the Department and conducted in accordance with N.J.A.C. 7:27B-4.10; and

6. For any motor vehicle that is subject to a recall notice issued to the owner on or after January 1, 1995, pursuant to either a "Voluntary Emissions Recall" as defined at 40 CFR 85.1902(d) or to a remedial plan determination made pursuant to 42 U.S.C.A. 7541(c), the provision by the owner of the motor vehicle of documentation that all applicable recall repairs have been completed; provided, however, for any recall notice received fewer than 60 days prior to inspection, provision of said documentation may, instead, be provided at the next scheduled vehicle inspection.

(f) Any on-road motor vehicle inspection test, conducted pursuant to N.J.S.A. 39:8 shall include the following:

1. A visible smoke test conducted in accordance with N.J.A.C. 7:27B-4.5(a); and

2. An idle test utilizing motor vehicle emission testing equipment approved by the Department and conducted in accordance with N.J.A.C. 7:27B-4.5(b).

(g) Any motor vehicle inspection test, conducted pursuant to N.J.S.A. 39:8 and using remote sensing techniques, shall include the following: (Reserved)

(h) For any motor vehicle subject to inspection pursuant to N.J.S.A. 39:8, compliance with the exhaust emission test requirements set forth at (e)2 above shall be determined as follows:

1. Prior to January 1, 1995, the inspection test procedure to be used shall be the idle test. This test is set forth at N.J.A.C. 7:27B-4.5(b);

2. During 1995, for no fewer than 30 percent of the 1968 and later model year vehicles required to have a motor vehicle inspection during the year, the inspection test procedure to be used shall be as specified at (h)3 below. The motor vehicles to be so tested shall be identified by the Division of Motor Vehicles in accordance with its procedures. For the remainder of the motor vehicles required to have a motor vehicle inspection, the inspection test procedure to be used shall be the idle test set forth at N.J.A.C. 7:27B-4.5(b);

3. In 1995, for the motor vehicles identified by the Division of Motor Vehicles, and after January 1, 1996, for all motor vehicles subject to this section, the inspection test procedure to be used shall be as follows:

i. For model year 1967 and earlier motor vehicles, the inspection test procedure to be used shall be the idle test set forth at N.J.A.C. 7:27B-4.5(b); and

ii. For model year 1968 and later motor vehicles, the inspection test procedure to be used shall be either the IM240 test or the fast-pass/fast-fail IM240 test, both of which are set forth at N.J.A.C. 7:27B-4.7;

4. Notwithstanding the provisions of (h)2 and 3 above, if the motor vehicle is any of the following types, the inspection test procedure to be used shall be the idle test set forth at N.J.A.C. 7:27B-4.5(b):

i. Motor vehicles that have a GVWR in excess of 8,500 pounds; or

ii. Motor vehicles that employ full-time four-wheel drive.

5. Notwithstanding the provisions of (h)2, 3, and 4 above, the 2500 RPM test in combination with the ASM5015 test as set forth at N.J.A.C. 7:27B-4.6 may be the test procedure used for any of the following:

i. LDGVs and LDGTs inspected at a Private Inspection Center pursuant to (c) above; or

ii. Prior to January 1, 1997, post-1967 model year LDGVs and LDGTs inspected at an official test-only inspection station operated by, or under contract with, the Division of Motor Vehicles in accordance with the following daily schedule:

(1) For the first 90 minutes of inspection station operation each day, the IM240 test shall be performed;

(2) After 90 minutes of operation, a given inspection station may switch to performance of the 2500 RPM test in combination with the ASM5015 test, rather than the IM240 test, under the following conditions:

(A) The average waiting time for an inspection at the station is in excess of 45 minutes;

(B) The overall lane throughput at the station is less than 15 vehicles per hour; and

(C) A determination has been made that the overall inspection throughput condition at (h)5ii(2)(B) above is not a result of any safety inspection operations being performed at that station.

(3) After two hours of operation using the 2500 RPM test in combination with the ASM5015 test, a given inspection station shall switch back to performance of the IM240 test as the exhaust emission test at such time during the day when the following conditions are met:

(A) The average waiting time is 15 minutes or less; and

(B) The time of day is 1:00 P.M. or earlier.

(4) A given inspection station may, for a second time that day, switch to performance of the 2500 RPM test in combination with the ASM5015 test as the exhaust emission test, after switching back to using the IM240 test, if the average waiting time is in excess of 30 minutes. In such case the inspection station shall perform the 2500 RPM test in combination with the ASM5015 test for the remainder of the day.

(i) Each year an evaluation test shall be performed on at least 0.1 percent of those motor vehicles subject to inspection during that year. The motor vehicles subject to evaluation testing shall be randomly selected by the Division of Motor Vehicles in accordance with its procedures. The evaluation test shall consist of a complete IM240 test performed in accordance with N.J.A.C. 7:27B-4.7(d). The evaluation test shall be performed in addition to any other inspection procedures required at N.J.A.C. 7:27-15.5(e).

(j) A motor vehicle that is subject to inspection pursuant to N.J.A.C. 13:20-43.2 and fails to pass all of the tests that comprise an inspection pursuant to (e) above shall be retested in accordance with this section within 30 days. Operation of the motor vehicle upon the public roads, streets or highways of the State or any public or quasi-public property in the State shall be prohibited pursuant to N.J.A.C. 7:27-15.3(c) unless, by the 30-day deadline:

1. The motor vehicle passes all of the tests that comprise the inspection; or

2. A waiver is issued pursuant to N.J.A.C. 7:27-15.10.

7:27-[15.4]**15.6** Motor vehicle inspection standards

(a) (No change.)

(b) Any light-duty or heavy-duty gasoline-fueled motor vehicle which is subject to inspection by the State of New Jersey in accordance with the provisions of N.J.S.A. 39:8, as a condition of compliance with said inspection, shall not emit carbon monoxide (CO) [or], hydrocarbons (HC), **or oxides of nitrogen (NO_x)** in the exhaust emissions in excess of [standards set forth in Table 1, when measured using an approved exhaust gas analytical system and] **the following standards:**

1. If, pursuant to the provisions of N.J.A.C. 7:27- 15.5(h) and the inspection test procedure [established] at N.J.A.C. 7:27B-4.5**(b)**[.], **a motor vehicle is tested using the idle test, the motor vehicle shall be subject to the exhaust emission standards set forth in Table 1 below;**

2. If, pursuant to the provisions of N.J.A.C. 7:27-15.5(h) and the inspection test procedure at N.J.A.C. 7:27B-4.6, a motor vehicle is tested using the 2500 RPM test and the ASM5015 test, the motor vehicle shall be subject to the applicable exhaust emission standards set forth in Tables 2 and 3 below, respectively;

3. If, pursuant to the provisions of N.J.A.C. 7:27-15.5(h) and the inspection test procedure at N.J.A.C. 7:27B-4.7(d), a motor vehicle is tested using the IM240 test, the motor vehicle shall be subject to the applicable exhaust emission standards set forth in Table 4 below; and

4. If, pursuant to the provisions of N.J.A.C. 7:27-15.5(h) and the inspection test procedure at N.J.A.C. 7:27B-4.7(e), a motor vehicle is tested using the fast-pass/fast-fail IM240 test, the motor vehicle

shall be subject to the applicable exhaust emission standards set forth in, or determined in accordance with the methodology set out in Appendix II, "Description of the IM240/Purge Fast-Pass/Fast-Fail Algorithm," and incorporated herein by reference. Regulatory Appendix 1 includes both standards to be used from January 1, 1995 through December 31, 1997 and standards to be used on and after January 1, 1998.

(c) [Any post-1974 model year] A gasoline-fueled motor vehicle [weighing less than 8501 pounds] which is subject to inspection by the State of New Jersey in accordance with the provisions of N.J.S.A. 39:8, as a condition of compliance with said inspection, shall have properly functioning and properly maintained emission control apparatus as determined according to the inspection test [procedure] **procedures** established at N.J.A.C. 7:27B-[4.6]**4.8, 4.9 and 4.10**.

(d) Except as provided in (e) and (f) below, the applicability of the standards set forth in this subchapter and of the test procedures set forth at N.J.A.C. 7:27B-4.5, 4.6, 4.7, 4.8, 4.9 and 4.10 to a motor vehicle with an engine other than the engine originally installed by the manufacturer, in accordance with N.J.A.C. 7:27-15.7, shall be based on the chassis type and model year of the motor vehicle, not on the engine model year.

(e) A motor vehicle that is modified, in accordance with N.J.A.C. 7:27-15.7, to operate on a fuel other than that for which the motor vehicle was originally equipped shall be subject to the test procedures and standards applicable to a motor vehicle of the current fuel type. If the motor vehicle's fuel type after modification is one to which this subchapter does not apply, the motor vehicle is not subject to emission testing (for example, a gasoline engine replaced with a diesel engine). If the motor vehicle's fuel type after modification is a fuel type to which this subchapter applies, but is other than gasoline (for example, a gasoline engine modified to operate solely on natural gas), the standards applied to that motor vehicle shall be those prescribed in the Tables 1, 2, 3, and 4 below for motor vehicles powered by a fuel other than gasoline. Until such time that applicable exhaust emission standards are promulgated for motor vehicles powered by fuels other than gasoline, such vehicles shall be exempt from exhaust emission testing when operating on a fuel other than gasoline.

TABLE 1
EXHAUST EMISSION STANDARDS
FOR THE IDLE TEST
[GASOLINE-FUELED MOTOR VEHICLES SUBJECT TO INSPECTION BY THE STATE OF NEW JERSEY]

[Light-Duty, Gasoline-Fueled Motor Vehicles]
LDGVs and LDGTs Powered by Gasoline

Model Year	[Idle] CO (% by volume)	[Idle] HC (ppm as hexane)
Pre-1968	8.5	1400
1968-1970	7.0	700
1971-1974	5.0	500
1975-1980	3.0	300
1981 & Later	1.2	220

LDGVs and LDGTs Powered by a Fuel Other Than Gasoline
(Reserved)

[Heavy-Duty, Gasoline-Fueled Motor Vehicles]
HDGVs Powered by Gasoline

Model Year	[Idle] CO (% by volume)	[Idle] HC (ppm as hexane)
Pre-1968	8.5	1400
1968-1970	8.5	1200
1971-1974	6.0	700
1975-1978	4.0	500
1979 & Later	3.0	300

HDGVs Powered by a Fuel Other Than Gasoline
(Reserved)

TABLE 2
EXHAUST EMISSION STANDARDS
FOR THE 2500 RPM TEST

LDGVs and LDGTs Powered by Gasoline

Model Year	CO (% by volume)	HC (ppm as hexane)
Pre-1968	8.5	1400
1968-1970	7.0	700
1971-1974	5.0	500
1975 & Later	0.5	100

LDGVs and LDGTs Powered by a Fuel Other Than Gasoline
(Reserved)

TABLE 3
EXHAUST EMISSION STANDARDS
FOR THE ASM5015 TEST

LDGVs Powered by Gasoline
(Effective through December 31, 1997)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1991 & Later	0.6	15.0	2.0
1983-1990	1.2	20.0	2.5
1981-1982	1.2	40.0	2.5
1980	1.2	40.0	5.0
1977-1979	4.5	60.0	5.0
1975-1976	4.5	60.0	7.5
1973-1974	6.0	100.0	7.5
1968-1972	6.0	100.0	8.0

LDGVs Powered by a Fuel Other Than Gasoline
(Effective through December 31, 1997)
(Reserved)

LDGT1s Powered by Gasoline
(Effective through December 31, 1997)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1991 & Later	1.2	45.0	2.4
1988-1990	1.6	60.0	2.8
1984-1987	1.6	60.0	5.6
1979-1983	3.8	75.0	5.6
1975-1978	4.0	90.0	7.2
1973-1974	5.0	110.0	7.2
1968-1972	5.0	110.0	8.0

LDGT1s Powered by a Fuel Other Than Gasoline
(Effective through December 31, 1997)
(Reserved)

LDGT2s Powered by Gasoline
(Effective through December 31, 1997)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1991 & Later	1.2	45.0	3.6
1988-1990	1.6	60.0	4.0
1984-1987	1.6	60.0	5.6
1979-1983	3.8	75.0	5.6
1975-1978	4.0	90.0	7.2
1973-1974	5.0	110.0	7.2
1968-1972	5.0	110.0	8.0

LDGT2s Powered by a Fuel Other Than Gasoline
(Effective through December 31, 1997)
(Reserved)

LDGVs Powered by Gasoline
(Effective January 1, 1998)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1994+ Tier 1	0.3	7.5	1.2
1983-1995	0.4	11.0	1.6
1981-1982	0.4	22.0	1.6
1980	0.4	22.0	3.2
1977-1979	1.5	48.0	3.2
1975-1976	1.5	48.0	4.8
1973-1974	3.5	90.0	4.8
1968-1972	3.5	90.0	5.6

LDGVs Powered by a Fuel Other Than Gasoline
(Effective January 1, 1998)
(Reserved)

LDGT1s Powered by Gasoline
(Effective January 1, 1998)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1994+ Tier 1			
(LVW≤3750)	0.3	7.5	1.2
(LVW≥3750)	0.4	9.8	1.4
1988-1995	0.8	30.0	1.9
1984-1987	0.8	30.0	3.4
1979-1983	1.7	50.0	3.4
1975-1978	2.0	60.0	4.5
1973-1974	3.5	90.0	4.5
1968-1972	3.5	90.0	5.2

LDGT1s Powered by a Fuel Other Than Gasoline
(Effective January 1, 1998)
(Reserved)

LDGT2s Powered by Gasoline
(Effective January 1, 1998)

Model Year	HC (g/mi)	CO (g/mi)	NO_x (g/mi)
1994+ Tier 1			
(LVW≤5750)	0.4	9.8	1.4
(LVW≥5750)	0.4	11.3	1.6
1988-1995	0.8	30.0	2.8
1984-1987	0.8	30.0	3.6
1979-1983	1.7	50.0	3.4
1975-1978	2.0	60.0	4.5
1973-1974	3.5	90.0	4.5
1968-1972	3.5	90.0	5.2

LDGT2s Powered by a Fuel Other Than Gasoline
(Effective January 1, 1998)
(Reserved)

TABLE 4
EXHAUST EMISSION STANDARDS FOR THE IM240 TEST

LDGVs Powered by Gasoline
(effective through December 31, 1997)

Model Years	HC (g/mi)		CO (g/mi)		NO_x (g/mi)	
	Composite	Phase 2	Composite	Phase 2	Composite	Phase 2
1994+ Tier I	0.80	0.50	15.0	12.0	2.00	(Reserved)
1986-1995	1.20	0.75	20.0	16.0	2.50	(Reserved)
1984-1985	1.20	0.75	30.0	24.0	3.00	(Reserved)
1983	2.00	1.25	30.0	24.0	3.00	(Reserved)
1981-1982	2.00	1.25	60.0	48.0	3.00	(Reserved)
1980	2.00	1.25	60.0	48.0	6.00	(Reserved)
1977-1979	7.50	5.00	90.0	72.0	6.00	(Reserved)
1975-1976	7.50	5.00	90.0	72.0	9.00	(Reserved)
1973-1974	10.0	6.00	150	120	9.00	(Reserved)
1968-1972	10.0	6.00	150	120	10.0	(Reserved)

LDGVs Powered by a Fuel Other Than Gasoline
(effective through December 31, 1997)
(Reserved)

LDGT1s Powered by Gasoline
(effective through December 31, 1997)

Model Years	HC (g/mi)		CO (g/mi)		NO_x (g/mi)	
	Composite	Phase 2	Composite	Phase 2	Composite	Phase 2
1994+ Tier 1						
(LVW≤3750)	0.80	0.50	15.0	12.0	2.0	(Reserved)
(LVW≥3750)	1.00	0.63	20.0	16.0	2.5	(Reserved)
1991-1995	2.40	1.50	60.0	48.0	3.0	(Reserved)
1988-1990	3.20	2.00	80.0	64.0	3.5	(Reserved)
1984-1987	3.20	2.00	80.0	64.0	7.0	(Reserved)
1979-1983	7.50	5.00	100	80.0	7.0	(Reserved)
1975-1978	8.00	5.00	120	96.0	9.0	(Reserved)
1973-1974	10.0	6.00	150	120	9.0	(Reserved)
1968-1972	10.0	6.00	150	120	10.0	(Reserved)

LDGT1s Powered by a Fuel Other Than Gasoline
(effective through December 31, 1997)
(Reserved)

LDGT2s Powered by Gasoline
(effective through December 31, 1997)

Model Years	HC (g/mi) Composite	HC (g/mi) Phase 2	CO (g/mi) Composite	CO (g/mi) Phase 2	NO_x (g/mi) Composite	NO_x (g/mi) Phase 2
1994+ Tier 1						
(LVW≤5750)	1.00	0.63	20.0	16.0	2.5	(Reserved)
(LVW≥5750)	2.40	1.50	60.0	48.0	4.0	(Reserved)
1991-1995	2.40	1.50	60.0	48.0	4.5	(Reserved)
1988-1990	3.20	2.00	80.0	64.0	5.0	(Reserved)
1984-1987	3.20	2.00	80.0	64.0	7.0	(Reserved)
1979-1983	7.50	5.00	100	80.0	7.0	(Reserved)
1975-1978	8.00	5.00	120	96.0	9.0	(Reserved)
1973-1974	10.0	6.00	150	120	9.0	(Reserved)
1968-1972	10.0	6.00	150	120	10.0	(Reserved)

LDGT2s Powered by a Fuel Other Than Gasoline
(effective through December 31, 1997)
(Reserved)

LDGVs Powered by Gasoline
(effective January 1, 1998)

Model Years	HC (g/mi) Composite	HC (g/mi) Phase 2	CO (g/mi) Composite	CO (g/mi) Phase 2	NO_x (g/mi) Composite	NO_x (g/mi) Phase 2
1994+ Tier 1	0.60	0.40	10.0	8.0	1.5	(Reserved)
1983-1995	0.80	0.50	15.0	12.0	2.0	(Reserved)
1981-1982	0.80	0.50	30.0	24.0	2.0	(Reserved)
1980	0.80	0.50	30.0	24.0	4.0	(Reserved)
1977-1979	3.00	2.00	65.0	52.0	4.0	(Reserved)
1975-1976	3.00	2.00	65.0	52.0	6.0	(Reserved)
1973-1974	7.00	4.50	120	96.0	6.0	(Reserved)
1968-1972	7.00	4.50	120	96.0	7.0	(Reserved)

LDGVs Powered by a Fuel Other Than Gasoline
(effective January 1, 1998)
(Reserved)

LDGT1s Powered by Gasoline
(effective January 1, 1998)

Model Years	HC (g/mi) Composite	HC (g/mi) Phase 2	CO (g/mi) Composite	CO (g/mi) Phase 2	NO_x (g/mi) Composite	NO_x (g/mi) Phase 2
1994+ Tier 1						
(LVW≤3750)	0.60	0.40	10.0	8.0	1.5	(Reserved)
(LVW≥3750)	0.80	0.50	13.0	10.0	1.8	(Reserved)
1988-1995	1.60	1.00	40.0	32.0	2.5	(Reserved)
1984-1987	1.60	1.00	40.0	32.0	4.5	(Reserved)
1979-1983	3.40	2.00	70.0	56.0	4.5	(Reserved)
1975-1978	4.00	2.50	80.0	64.0	6.0	(Reserved)
1973-1974	7.00	4.50	120	96.0	6.0	(Reserved)
1968-1972	7.00	4.50	120	96.0	7.0	(Reserved)

LDGT1s Powered by a Fuel Other Than Gasoline
(effective January 1, 1998)
(Reserved)

LDGT2s Powered by Gasoline
(effective January 1, 1998)

Model Years	HC (g/mi) Composite	HC (g/mi) Phase 2	CO (g/mi) Composite	CO (g/mi) Phase 2	NO_x (g/mi) Composite	NO_x (g/mi) Phase 2
1994+ Tier 1						
(LVW≤5750)	0.80	0.50	13.0	10.0	1.8	(Reserved)
(LVW≥5750)	0.80	0.50	15.0	12.0	2.0	(Reserved)
1988-1995	1.60	1.00	40.0	32.0	3.5	(Reserved)
1984-1987	1.60	1.00	40.0	32.0	4.5	(Reserved)
1979-1983	3.40	2.00	70.0	56.0	4.5	(Reserved)
1975-1978	4.00	2.50	80.0	64.0	6.0	(Reserved)
1973-1974	7.00	4.50	120	96.0	6.0	(Reserved)
1968-1972	7.00	4.50	120	96.0	7.0	(Reserved)

LDGT2s Powered by a Fuel Other Than Gasoline
(effective January 1, 1998)
(Reserved)

(f) A motor vehicle that is modified, in accordance with N.J.A.C. 7:27-15.7, or manufactured to operate on more than one fuel type shall be subject to exhaust emission standards that apply to the motor vehicle for each fuel type for which the motor vehicle is equipped. Such motor vehicle shall be subject to an exhaust emission test for each fuel type on which it operates and shall comply with all applicable standards for each fuel type. Such motor vehicle shall also be subject to an evaporative pressure test and an evaporative purge test when operating on gasoline. If the motor vehicle is capable of simultaneous operation on more than one fuel type (for example, flexible fuel, gasoline-methanol vehicle), the motor vehicle shall be subject to an exhaust emission test using the fuel mixture in the vehicle at the time of inspection. When operating on a fuel other than gasoline, the exhaust emission standards applied to a motor vehicle shall be those prescribed in the Tables 1, 2, 3, and 4 above for motor vehicles powered by a fuel other than gasoline. Until such time that applicable exhaust emission standards are promulgated for motor vehicles powered by fuels other than gasoline, such vehicles shall be exempt from exhaust emission testing when operating on a fuel other than gasoline.

7:27-[15.5]**15.7** [Operation of emission control apparatus] **Prohibition of tampering with emission control apparatus**

(a) **No person shall cause, suffer, allow or permit any of the following, unless in accordance with EPA Memorandum 1A or exempt from prohibition by CARB executive order (information on devices or modifications approved by CARB executive order may be obtained from Air Resources Board, Haagen-Smit Laboratory, 9528 Telstar Avenue, El Monte, CA 91731-2990):**

1. [No person shall cause, suffer, allow or permit any emission control apparatus] **The disconnection, detachment, deactivation, or any other alteration or modification from the design of the original vehicle manufacturer of an element of design** installed on any motor vehicle **with a certified configuration** [to be disconnected, detached, deactivated, or in any other way rendered inoperable or less effective than designed by the original equipment manufacturer], [(]except temporarily for the purpose of diagnosis, maintenance, repair or replacement[).];

[(b)]**2.** [No person shall cause, suffer, allow or permit the] **The** operation on the public **roads, streets or** highways **of the State or any public or quasi-public property in the State** of any motor vehicle **with a certified configuration** in which **any** [emission control apparatus] **element of design** installed on such vehicle has been disconnected, detached, deactivated, or in any other way [rendered inoperable or less effective than designed by] **altered or modified from the design of** the original [equipment] **vehicle** manufacturer[.];

[(c)]**3.** [No person shall cause, suffer, allow or permit the] **The** sale**, lease, or offer for sale or lease, of** any motor vehicle **with a certified configuration** in which [emission control apparatus] **any element of design** installed on such vehicle has been disconnected, detached, deactivated, or in any other way [rendered inoperable or less effective than designed by] **altered or modified from the design of** the original [equipment] **vehicle** manufacturer[.]**; and**

4. The sale, or offer for sale, of any device or component as an element of design intended for use with, or as part of, any motor vehicle or motor vehicle engine with a certified configuration, which is not designed to duplicate the function and performance of any element of design installed by the original vehicle manufacturer.

7:27-[15.6]**15.8** Idle standard

(a) No person shall cause, suffer, allow, or permit the engine of a gasoline-fueled motor vehicle to idle for more than three consecutive minutes if the vehicle is not in motion[, except:

1. A motor vehicle at the vehicle operator's place of business where the motor vehicle is permanently assigned may idle for 30 consecutive minutes, or

2. A motor vehicle may idle for 15 consecutive minutes when the vehicle engine has been stopped for three or more hours].

(b) (No change.)

7:27-[15.7 Exceptions]**15.9 Non-interference with the motor vehicle codes**

[(a) This subchapter shall not apply to motorcycles or to motor vehicles with an engine displacement of less than 50 cubic inches (819 cubic centimeters).]

[(b)] Nothing in this subchapter is intended to limit or deny the inspection of motor vehicles for exhaust systems in accordance with regulations established pursuant to N.J.S.A. 39:8-2, 39:3-70, 39:3-76, and 39:10-26.

[7:27-15.8 Variances]

[Whenever either the Commissioner or the Director, Division of Motor Vehicles, has reason to believe that any vehicle or any vehicle class cannot comply with the provisions of N.J.A.C. 7:27-15.4(b), the Director, with the concurrence of the Commissioner, may prescribe alternative emission inspection standards for such vehicle or vehicle class.]

7:27-15.10 Cost waivers

(a) Notwithstanding the provisions of N.J.A.C. 7:27-15.3, a person may cause, suffer, allow or permit the operation of a gasoline-fueled motor vehicle which fails to meet the applicable motor vehicle inspection testing requirements at N.J.A.C. 7:27-15.5 upon the public roads, streets, or highways of the State and upon any public or quasi-public property in the State, provided that the State has issued to the owner of the motor vehicle, pursuant to this section, a waiver of the requirement to meet these standards.

(b) A waiver issued pursuant to this section shall relieve the owner of a motor vehicle from responsibility for taking any further action to reduce exhaust and evaporative emissions from the motor vehicle until the motor vehicle is next due for inspection, pursuant to N.J.S.A. 39:8.

(c) Any owner of a motor vehicle may apply to the State for a waiver pursuant to this section if:

1. The motor vehicle, when tested in accordance with N.J.A.C. 7:27-15.5, is determined to have failed the motor vehicle inspection;

2. For a motor vehicle within a warranty period established pursuant to 42 U.S.C.A. 7541, the owner has used all available warranty coverage to have repairs made that are directed toward correcting the cause of the motor vehicle's failure to meet the applicable exhaust and evaporative emission standards;

3. Repairs are made pursuant to (c)2 above and (d) below, and the motor vehicle is determined to have failed the motor vehicle inspection when retested in accordance with N.J.A.C. 7:27- 15.5; and

4. The owner of the motor vehicle qualifies to apply for a waiver pursuant to (d) below.

(d) For an owner of a motor vehicle to qualify to apply for a cost waiver, the owner shall have expended on repair of the motor vehicle, subsequent to the inspection test failure specified at (c)1 above, no less than the current dollar equivalent of $450.00, in 1989 dollars, determined in accordance with (e) below; and the following:

1. The following types of expenditures may not be credited toward meeting this minimum $450.00 amount:

i. Monies expended for repairs that are directed other than to correcting the cause of the emission test failure; and

ii. Monies expended for tampering-related repairs. Such repairs are specifically those repairs needed to correct any acts prohibited at N.J.A.C. 7:27-15.7(a)1;

2. For a 1980 model year or later motor vehicle, only monies expended for repairs performed by a professional repair technician may be credited toward meeting the minimum amount; and

3. For a pre-1980 model year motor vehicle, monies expended for the following may be credited toward meeting the minimum amount:

i. For repairs performed by a professional repair technician, any monies expended on the repairs; and

ii. For repairs performed by a person who is not a professional repair technician, only the direct costs of parts and components.

(e) The current dollar equivalent of $450.00, in 1989 dollars, is calculated as follows:

current dollars = $450.00 × (most recent CPI)/(1989 CPI)
Where:

current dollars =	**current value of $450.00 expressed in 1989 dollars;**
1989 CPI =	**Consumer Price Index for the calendar year 1989 (that is, 124.0); and**
most recent CPI =	**Consumer Price Index for the most recent calendar year.**

(f) The State shall approve a request for a waiver only if the owner of the motor vehicle provides the following in the application for the waiver:

1. If the motor vehicle is within an applicable warranty period established pursuant to 42 U.S.C.A. 7541:

i. Documentation indicating that any available warranty coverage has been used to have the repairs made that are directed toward correcting the cause of the motor vehicle's failure to pass the motor vehicle inspection; or

ii. A written denial of warranty coverage for the needed repairs from the manufacturer or authorized dealer;

2. Receipt or receipts documenting that no less than the minimum amount required pursuant to (d) above has been expended on the repair of the motor vehicle;

(g) If, given their nature, the repairs performed pursuant to (c)2 or (d) above can be visually confirmed, the State shall approve a request for a waiver only if, in addition to compliance with (f) above, visual inspection of the motor vehicle during retesting performed pursuant to (c)3 above confirms that the repairs have been made.

7:27A-3.10 Civil Administrative Penalties for Violations of Rules Adopted Pursuant to the Act

(a)-(d) (No change.)

(e) The Department shall determine the amount of civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. Footnotes 3, 4, and 8 set forth in this subsection are intended solely to put violators on notice that in addition to any civil administrative penalty assessed the Department may also revoke the violator's operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to seek revocation. The number of the following subsections corresponds to the number of the corresponding subchapter in N.J.A.C. 7:27.

1.-14. (No change.)

15. The violations of N.J.A.C. 7:27-15, Control and Prohibition of Air Pollution from Gasoline-fueled Motor Vehicles, and the civil administrative penalty amounts for each violation, per vehicle **or, with respect to N.J.A.C. 7:27-15.7(a)4, per device/component**, are as set forth in the following table:

Citation	Class	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-15.3(d)	**Passenger Vehicle Registration**	**$ 500**	**$1,000**	**$ 2,500**	**$ 7,500**
	Commercial Vehicle Registration	**$1,000**	**$2,000**	**$ 5,000**	**$15,000**
[N.J.A.C. 7:27-15.5(a)]					
N.J.A.C. 7:27-15.7(a)1	Owner of **four or** fewer [than three] vehicles	$ 400	$ 800	$ 2,000	$ 6,000
	[All other (e.g. Fleet, Motor Vehicle Dealer & Repair/Service Center)] **Owner of five or more vehicles**	$1,000	$2,000	$ 5,000	$15,000
[N.J.A.C. 7:27-15.5(b)]					
N.J.A.C. 7:27-15.7(a)2	Passenger Vehicle Registration	$ 500	$1,000	$ 2,500	$ 7,500
	Commercial Vehicle Registration	$1,000	$2,000	$ 5,000	$15,000
[N.J.A.C. 7:27-15.5(c)]					
N.J.A.C. 7:27-15.7(a)3	**Sale/Offer for Sale; Lease/Offer for Lease by owner of four or fewer vehicles**	**$1,000**	**$2,000**	**$ 5,000**	**$15,000**
	Sale/Offer for Sale; Lease/Offer for Lease by owner of five or more vehicles	$2,000	$4,000	$10,000	$30,000
N.J.A.C. 7:27-15.7(a)4	**Offer for Sale/Sale of Device/Component**	**$2,000**	**$4,000**	**$10,000**	**$30,000**
[N.J.A.C. 7:27-15.6(a)]					
N.J.A.C. 7:27-15.8(a)	Passenger Vehicle Registration	$ 100	$ 200	$ 500	$ 1,500
	Commercial Vehicle Registration	$ 200	$ 400	$ 1,000	$ 3,000
	Property Owner	$ 200	$ 400	$ 1,000	$ 3,000

16.-25. (No change.)

SUBCHAPTER 4. AIR TEST METHOD 4: TESTING PROCEDURES FOR MOTOR VEHICLES

7:27B-4.1 Definitions

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

...

"Chassis dynamometer **or dynamometer"** means a device constructed in such manner as [a] **to** simulate highway driving conditions on a stationary motor vehicle.

["Diesel-powered motor vehicle" means a vehicle which is self-propelled by a compression ignition type of internal combustion engine and which is designed primarily for transporting persons or property on public streets or highways; for purposes of this Subchapter, passenger automobiles and motorcycles are excluded.]

...

"EPA" means the United States Environmental Protection Agency.

...

"Gasoline-fueled" means powered by a hydrocarbon fuel other than diesel fuel, including, but not limited to, gasoline, natural gas, liquified petroleum gas, and propane, and also powered by alcohol fuels, hydrocarbon-alcohol fuel blends and hydrogen.

["Gasoline-fueled motor vehicle" means any motor vehicle equipped to be powered by a hydrocarbon fuel other than diesel

fuel, but including alcohol fuels and hydrocarbon-alcohol fuel blends.]

"Gross vehicle weight rating (GVWR)" means the value specified by the manufacturer as the maximum loaded weight of a single or combination vehicle.

"Heavy-duty diesel vehicle (HDDV)" means a vehicle that has a GVWR exceeding 8,500 pounds, is self-propelled by a compression ignition type of internal combustion engine, uses diesel oil as its fuel, and is designed primarily for transporting persons or property.

"Heavy-duty [motor] **gasoline-fueled** vehicle **(HDGV)**" means [any] **a gasoline-fueled** motor vehicle **that has a GVWR exceeding 8,500 pounds and that is** designed primarily for transportation of persons or property [and registered as exceeding 6,000 pounds gross weight].

...

"Inertia weight" means the vehicle curb weight plus 300 pounds.

...

"Light-duty gasoline-fueled vehicle (LDGV)" means a gasoline-fueled motor vehicle that has a GVWR of 8,500 pounds or less, is designed primarily for use as a passenger car or is a passenger car derivative and is capable of seating 12 or fewer passengers.

"Light-duty gasoline-fueled truck (LDGT)" means a gasoline-fueled motor vehicle that has a GVWR of 8,500 pounds or less, a vehicle curb weight of 6,000 pounds or less, and a basic frontal area of 45 square feet or less, and that is:

1. Designed primarily for the transportation of property or more than 12 passengers; or

2. Available with special features enabling off-street or off-highway operation and use.

"Light-duty gasoline-fueled truck 1 (LDGT1)" means a light- duty gasoline-fueled truck with a GVWR of 6,000 pounds or less.

"Light-duty gasoline-fueled truck 2 (LDGT2)" means a light- duty gasoline-fueled truck with a GVWR of more than 6,000 pounds.

["Light-duty motor vehicle" means any motor vehicle designed primarily for transportation of persons or property and registered at 6,000 pounds gross weight or less.]

"Motor vehicle emission testing equipment" means equipment in accordance with specifications contained in Appendix 7 ("Specifications For Motor Vehicle Emission Testing Equipment For Use in the New Jersey Enhanced Inspection and Maintenance Program") to this chapter, incorporated herein by reference. The equipment shall include all devices used for performing a motor vehicle inspection, including, but not limited to, exhaust gas analyzers, evaporative pressure testing apparatus, evaporative purge testing apparatus, dynamometers, computers and related software.

...

"Tier 1 Standards" means standards prescribed at section 202(g) of the Clean Air Act, 42 U.S.C.A. 7521(g), for model years 1994 and later, LDGT1s and LDGVs.

"Vehicle curb weight" means the actual weight of a motor vehicle in operational status or the weight given by the manufacturer for such a vehicle. Such weight shall include the weight of all standard equipment, of the fuel at nominal tank capacity, and of optional equipment computed in accordance with 40 CFR §86.082-24. This term, with respect to an incomplete light-duty gasoline-fueled truck, shall be the weight given by the manufacturer for such a truck.

7:27B-4.5 [Exhaust emission testing procedure for gasoline-fueled motor vehicles subject to inspection by the State of New Jersey] **Procedures for the visible smoke test and the idle test**

(a) The [exhaust emission] testing procedure for [gasoline-fueled motor vehicles] **the visible smoke test, to be used** to determine **a motor vehicle's** compliance with [N.J.A.C. 7:27-15.2(b), and 15.4(a) and (b)] **the standard set forth at N.J.A.C. 7:27- 15.6(a)** shall be [the following:

1. The smoke test shall be] performed as follows:

[i. Place the] **1. The** vehicle **shall be placed** in neutral gear with all accessories off and the [handbrake] **emergency or parking brake** secured;

[ii. Accelerate the engine] **2. The engine speed shall be increased to an engine speed greater than the idle mode,** and **the exhaust emissions and crankcase emissions observed** [observe] for visible continuous smoke [in the exhaust emissions and crankcase emissions]; **and**

[iii. Visible] **3. If there is visible** smoke in the exhaust emissions or crankcase emissions for a period in excess of three consecutive seconds, **the motor vehicle** shall be [a cause for rejection] **determined to fail to meet the standard.**

[2. The emission test at idle mode] **(b) The testing procedure for the idle test, to be used to determine a motor vehicle's compliance with the exhaust emission standards set forth at N.J.A.C. 7:27-15.6(b)1 is the idle test and** shall be performed as follows:

[i. Engines] **1. The engine** shall be at normal operating temperature and not overheating (as [indicated] **determined** by **the vehicle's temperature** gauge **or temperature** warning light, [or] **a** boiling radiator, **or other visual observation**) with all accessories off;

[ii.]**2.** With **the** engine operating in the idle mode and transmission [is] **in** neutral, the sample probe shall be inserted at least [six] **ten** inches into the exhaust outlet;

[iii.]**3.** [Record] **The** exhaust concentrations **shall be** measured as percent carbon monoxide and parts per million hydrocarbons after stabilized readings are obtained or at the end of 30 seconds, whichever occurs first; **and**

[iv.]**4.** [These exhaust concentrations shall be the inspection results.] **If the percent carbon monoxide or parts per million hydrocarbons recorded in (b)3 above exceeds the applicable standards specified in Table 1 at N.J.A.C. 7:27-15.6, the motor vehicle shall be determined to fail to meet the standard.**

7:27B-4.6 Procedure for the ASM5015 test and the 2500 RPM test

(a) The testing procedure for the ASM5015 test and the 2500 RPM test, to be used to determine a motor vehicle's compliance with the exhaust emission standards set forth at N.J.A.C. 7:27-15.6(b)2 shall consist of an ASM5015 test followed by a 2500 RPM test.

(b) A motor vehicle shall be tested pursuant to (a) above in as-received condition with all accessories off. Its engine shall be at normal operating temperature and not overheating (as determined by the vehicle's temperature gauge or temperature warning light, a boiling radiator, or other visual observation).

(c) The ASM5015 test shall be initiated as follows:

1. The dynamometer shall be warmed up, in stabilized operating condition, adjusted and calibrated in accordance with the procedures recommended by the dynamometer manufacturer;

2. The motor vehicle shall be positioned on the dynamometer and, if necessary, secured according to protocol recommended by the dynamometer manufacturer; and

3. The evaporative purge test apparatus shall be connected and the procedures for the evaporative purge test shall be performed as specified in N.J.A.C. 7:27B-4.10; or for those motor vehicles identified as requiring a specific procedure, other than the ASM5015 test, to activate their evaporative system purge, such procedure shall be run at this time in the manner and duration determined by the Division of Motor Vehicles;

4. The dynamometer shall be set at a load setting determined by the following equation:

$$L = IW/250$$

where:

L = load, in horsepower; and
IW = vehicle inertia weight, in pounds;

5. The sample probe shall be inserted into the motor vehicle's tailpipe to a minimum depth of 10 inches. If the motor vehicle's exhaust system prevents insertion to this depth, a tailpipe extension shall be used. For motor vehicles equipped with multiple exhaust pipes, exhaust gas measurements shall be taken from all exhaust pipes simultaneously;

6. The tachometer or other means determined by the Director of the Division of Motor Vehicles shall be used to measure engine speed. When engine speed is being measured with a tachometer, the tachometer shall be attached to the motor vehicle in accordance with the analyzer manufacturer's instructions; and

7. A motor vehicle with an automatic transmission shall be operated during the ASM5015 test with the gear selector in drive, and a motor vehicle with a manual transmission shall be operated in first (or, if more appropriate, second) gear.

(d) At the beginning of the ASM5015 test, the motor vehicle shall be accelerated to a speed of 15 MPH as indicated on the dynamometer speed indicator. This speed shall be maintained, ±1.0 MPH, for the test duration. The test duration shall be determined as follows:

1. If the following fast-pass criteria are met within 30 seconds, the ASM5015 test shall be terminated after 30 seconds:

i. Measurement of the hydrocarbons and carbon monoxide in the exhaust emissions 30 seconds after beginning the test indicates that the concentration of each of these air contaminants is less than or equal to 60 percent of the applicable standards established in Table 3 at N.J.A.C. 7:27-15.6; and

ii. Measurement of the oxides of nitrogen in the exhaust emissions 30 seconds after beginning the test indicates that its concentration is less than or equal to the applicable standard established in Table 3 at N.J.A.C. 7:27-15.6.

2. If any one of the criteria at (d)1 is not met, the ASM5015 test shall be terminated after 90 seconds.

(e) Under either of the following circumstances, a determination shall be made that the motor vehicle has passed the ASM5015 test:

1. The motor vehicle meets the criteria for fast pass in (d)1 above; or

2. The measurements made of the hydrocarbons, carbon monoxide and oxides of nitrogen in the exhaust emissions made pursuant to (d)2 above indicates that the concentration of each of these air contaminants is less than or equal to the applicable standards established in Table 3 at N.J.A.C. 7:27-15.6.

(f) The ASM5015 test shall be concluded by placing the vehicle's transmission in park or neutral after safely bringing the vehicle's drive wheels to a complete stop using the vehicle's brakes.

(g) A 2500 RPM test shall then be conducted as follows:

1. The vehicle engine speed shall be increased from idle to between 2200 and 2800 RPM and maintained at that level for the duration of the test, not to exceed 30 seconds. If the engine speed falls and remains below 2200 RPM or exceeds and remains above 2800 RPM for more than two consecutive seconds during the test period, the measured value shall be invalidated for that sampling period and the test duration extended accordingly. If any excursion outside of the allowable RPM range lasts for more than 10 seconds, the test shall be invalidated, and another 2500 RPM test shall be initiated;

2. Exhaust concentrations shall be measured as percent carbon monoxide and parts per million hydrocarbons after stabilized readings are obtained or at the end of 30 seconds, whichever occurs first.

(h) A determination shall be made that the motor vehicle has failed the 2500 RPM test if the measurements made of the hydrocarbons and carbon monoxide in the exhaust emissions indicate that the concentration of either of these air contaminants is greater than the applicable standards specified in Table 2 at N.J.A.C. 7:27-15.6.

7:27B-4.7 Procedures for the IM240 test and the fast-pass/fast-fail IM240 test

(a) The testing procedure for the IM240 test, to be used to determine a motor vehicle's compliance with the exhaust emission standards set forth at N.J.A.C. 7:27-15.6(b)3 or (b)4, requires performing the IM240 test or the fast-pass/fast-fail IM240 test.

(b) The IM240 testing procedure may be used on all motor vehicles subject to the exhaust emission test in accordance with N.J.A.C. 7:27-15.5(h).

(c) The fast-pass/fast-fail IM240 testing procedure may be used on all motor vehicles subject to the exhaust emission test in accordance with N.J.A.C. 7:27-15.5(h).

(d) The procedures for the IM240 test are specified as follows:

1. On and after the date EPA promulgates the exhaust test procedures to be used for the IM240 test at 40 CFR §85.2221, such procedures and all subsequent revisions thereto shall be incorporated herein by reference;

2. Until EPA promulgates such procedures, the applicable procedures shall be those described in the EPA report EPA-AA-EPSD-IM-93-1, entitled High-Tech I/M Test Procedures, Emission Standards, Quality Control Requirements, and Equipment Specifications, April 1994, incorporated herein by reference. A copy of this EPA report has been filed with the Office of Administrative Law and may be obtained from the Bureau of Transportation Control in the Department. The standards to be applied to determine if a motor vehicle passes or fails shall be those specified at N.J.A.C. 7:27-15.6(b)3.

(e) The procedures for the fast-pass/fast-fail IM240 test are specified as follows:

1. On and after the date EPA promulgates the exhaust test procedures to be used for the IM240 test at 40 CFR §85.2221 and the fast-pass/fast-fail algorithm at 40 CFR §85.2205, such procedures and all subsequent revisions thereto shall be incorporated herein by reference;

2. Until EPA promulgates such procedures, the applicable procedures shall be those described in the EPA report EPA-AA-EPSD-IM-93-1, entitled High-Tech I/M Test Procedures, Emission Standards, Quality Control Requirements, and Equipment Specifications, April 1994, incorporated herein by reference. A copy of this EPA report has been filed with the Office of Administrative Law and may be obtained from the Bureau of Transportation Control in the Department. The standards to be applied to determine if a motor vehicle passes or fails shall be those specified at N.J.A.C. 7:27-15.6(b)4.

7:27B-[4.6]4.8 [Gasoline-fueled motor vehicle emission] **Emission** control apparatus [compliance] examination procedure

(a) The **procedure for** examination of the [motor vehicle] emission control apparatus [of all post-1974 model year gasoline-fueled motor vehicles under 8501 pounds to determine compliance with N.J.A.C. 7:27-15.4(c), when conducted during periodic scheduled inspection and random roadside inspection,] **of a motor vehicle, required at N.J.A.C. 7:27-15.5(e)3,** shall, **if the motor vehicle had a catalytic converter as original equipment,** consist of [the following three examinations:

1. A] a visual check to determine [the] **whether a** [presence of] properly installed catalytic [converters on motor vehicles] **converter is present on the motor vehicle** [designed and marketed by the vehicle manufacturer with catalytic converters as original equipment].

(b) The absence of [such] **a** properly installed catalytic converter[s,] shall [be cause for vehicle rejection] **result in a determination of failure of the motor vehicle inspection.**

(c) **A** [Rejected vehicles] **motor vehicle that has failed inspection in accordance with (b) above** shall be required to be properly equipped with [new or used] **a** replacement catalytic [converters] **converter** certified according to [U.S. Environmental Protection Agency] **EPA** procedures and subsequently [reexamined] **reinspected.** The [reexamination] **reinspection** shall consist of a visual check to [document] **verify the** proper installation of [a] **an appropriate** replacement catalytic converter.

[2. (Reserved)

3. An examination consisting of a visual inspection for the presence of, or malfunction of the fuel filler neck inlet restrictor on motor vehicles designed and marketed by the vehicle manufacturer for operation with unleaded fuel only. Rejected vehicles shall be required to be properly equipped with new or used replacement catalytic converters certified according to U.S. Environmental Protection Agency procedures and a new fuel filler neck inlet restrictor. Reexamination shall consist of a visual check to document proper installation of a replacement catalytic converter and fuel filler neck inlet restrictor.

i. The fuel filler neck inlet restrictor examination shall be conducted in the following manner:

(1) Attempt to insert a dowel, with a diameter equivalent to that of a standard leaded fuel rump nozzle, into the fuel filler neck.

(2) The absence of the fuel filler neck inlet restrictor is verified if the dowel can be inserted and shall be cause for vehicle rejection.

(b) Inspection of gasoline-fueled motor vehicles for (a) above shall be implemented by model year and registered weight in accordance with the following schedule:

DATE	MODEL YEAR	REGISTERED WEIGHT
December 1, 1985	1985 and later	Under 6001 pounds
May 1, 1986	1982 and later	Under 6001 pounds
July 1, 1986	1982 and later	Under 8501 pounds
January 1, 1987	1979 and later	Under 8501 pounds
May 1, 1987	1975 and later	Under 8501 pounds]

[7:27B-4.7 Gasoline-fueled motor vehicle exhaust lead determination procedure

(a) An examination using lead test paper to determine the presence of lead in the vehicle exhaust shall be performed on the following vehicles:

1. All post-1974 model year gasoline-fueled motor vehicles weighing less than 8501 pounds which are designed and marketed by the vehicle manufacturer for operation with unleaded fuel only and which are determined during annual inspection and random roadside inspection to have improperly functioning or improperly maintained emission control apparatus as determined according to the inspection test procedure established at N.J.A.C. 7:27B-4.6.

2. One percent of all post-1974 model year gasoline-fueled motor vehicles weighing less than 8501 pounds which are designed and marketed by the vehicle manufacturer for operation with unleaded fuel only and which are determined during annual inspection and random roadside inspection to have properly functioning and properly maintained emission control apparatus as determined according to the inspection test procedure established at N.J.A.C. 7:27B-4.6.

(b) The lead test paper examination shall be conducted in the following manner:

(i) Remove test paper from package and moisten with distilled water;

(ii) Wipe a small section of the tailpipe with a cloth;

(iii) Attach moistened paper onto the cleaned surface of the tailpipe with a clip; and

(iv) Remove paper.

(v) The presence of lead in the vehicle exhaust is indicated by the lead paper changing to a pink or red color.

(c) The test result for vehicles examined according to the inspection test procedures established at (b) above shall be recorded by the New Jersey Division of Motor Vehicles and forwarded monthly to the Department of Environmental Protection.

(d) The presence of lead in the vehicle exhaust, if determined solely according to the inspection test procedure established at (b) above shall not be cause for vehicle rejection.

(e) This section shall not apply to vehicle examinations performed by private inspection centers licensed by the Division of Motor Vehicles.

(f) This section shall expire on October 1, 1986.]

7:27B-4.9 Procedures for the evaporative pressure test

(a) The testing procedure for the evaporative pressure test, to be used to determine a motor vehicle's compliance with the evaporative pressure test requirements at N.J.A.C. 7:27-15.5(e)4, shall be conducted in accordance with either (b) or (c) below.

(b) The procedure for the evaporative pressure test may be as follows:

1. The test shall be initiated as follows:

i. The gas cap shall be removed and the appropriate gas cap adapter connected to the filler neck;

ii. The gas cap shall be connected to the gas cap test rig;

iii. The hood of the motor vehicle shall be opened and the vapor line connecting the evaporative canister to the gas tank clamped as close as possible to the evaporative canister. If the vapor line cannot be clamped, it shall be removed from the evaporative canister and plugged so as to prevent leakage;

iv. The gas cap shall be pressurized with nitrogen, or a functionally equivalent gas, to a pressure of 14q0.5 inches of water for a maximum of 10 seconds, the flow shut off, and the pressure decay monitored for 10 seconds; and

v. The gas tank shall be pressurized with nitrogen, or a functionally equivalent gas, to a pressure of 14 ± 0.5 inches of water with a flow rate of 10 liters per minute, the flow shut off, and the pressure decay monitored for up to two minutes.

2. If, at any time during the two minutes that the gas tank pressure decay is monitored, the evaporative system pressure drops from the starting pressure by six or more inches of water, the test shall be terminated and the motor vehicle shall be determined to fail the evaporative pressure test;

3. If, at any time during the 10 seconds that the gas cap pressure decay is monitored, the gas cap pressure drops from the starting pressure by six or more inches of water, the motor vehicle shall be determined to fail the evaporative pressure test; and

4. The test shall be concluded by removing the gas cap adapter from the filler neck, removing the gas cap from the gas cap test rig and replacing the gas cap on the filler neck.

(c) The evaporative pressure test may be performed in accordance with 40 CFR §51.357(a)(10), incorporating all subsequent revisions thereto.

7:27B-4.10 Procedures for the evaporative purge test

(a) The testing procedure for the evaporative purge test, to be used to determine a motor vehicle's compliance with the evaporative purge test requirements at N.J.A.C. 7:27-15.5(e)5, shall be conducted in accordance with either (b) or (c) below.

(b) The procedure for the evaporative purge test may be as follows:

1. The test shall be initiated as follows:

i. The gas cap shall be removed, the appropriate filler adapter connected and the helium flow into the gas tank started;

ii. The exhaust emission test procedures specified at N.J.A.C. 7:27B-4.6 or N.J.A.C. 7:27B-4.7 shall be carried out;

iii. The helium concentration in the exhaust emissions shall be measured concurrently with the exhaust emission test being performed in accordance with N.J.A.C. 7:27B-4.6 or N.J.A.C. 7:27B-4.7; and

iv. If the measured helium concentration is less than 25 ppm, the motor vehicle shall be determined to fail the evaporative purge test.

(c) The evaporative purge test may be performed in accordance with the following:

1. On and after the date EPA promulgates procedures to be used for the evaporative purge test with the IM240 test at 40 CFR §85.2221 or procedures to be used with the fast-pass/fast-fail IM240 test at 40 CFR §85.2221 and 40 CFR §2205(c), or both, such procedures and all subsequent revisions thereto shall be incorporated herein by reference; and

2. Until EPA promulgates such procedures, the procedures to be used shall be:

i. For a motor vehicle being tested with an IM240 test in accordance with N.J.A.C. 7:27B-4.7(d) or an ASM5015 test in accordance with N.J.A.C. 7:27B-4.6, those procedures described in the EPA report EPA-AA-EPSD-IM-93-1, entitled High-Tech I/M Test Procedures, Emission Standards, Quality Control Requirements, and Equipment Specifications, April 1994, incorporated herein by reference (A copy of this EPA report has been filed with the Office of Administrative Law and may be obtained from the Bureau of Transportation Control in the Department); and

ii. For a motor vehicle being tested with a fast-pass/fast-fail IM240 test in accordance with N.J.A.C. 7:27B-4.7(e), those procedures described in the EPA report EPA-AA-EPSD-IM-93-1, entitled High-Tech I/M Test Procedures, Emission Standards, Quality Control Requirements, and Equipment Specifications, April 1994, incorporated herein by reference (A copy of this EPA report has been filed with the Office of Administrative Law and may be obtained from the Bureau of Transportation Control in the Depart-

ment); and those procedures set forth in N.J.A.C. 7:27, Appendix II, "Description of the IM240/Purge Fast-Pass/Fast-Fail Algorithm," and incorporated herein by reference.

7:27B-4.11 Procedure for On-Board Diagnostics Testing (Reserved)

APPENDIX 7
SPECIFICATIONS FOR MOTOR VEHICLE EMISSION TESTING EQUIPMENT FOR USE IN THE NEW JERSEY ENHANCED INSPECTION AND MAINTENANCE PROGRAM (RESERVED)

APPENDIX II

Description of the IM240/Purge Fast-Pass/Fast-Fail Algorithm

Pass and fail decisions are made by measuring the vehicle's cumulative emissions of each pollutant in each second, and comparing them to cumulative emission fast-pass and fast-fail standards for each pollutant for the second of the test under consideration. In general, if the vehicle's cumulative emissions are above a given level for any pollutant the vehicle fails, if they are below a given level for all pollutants the vehicle passes. Testing continues until decisions are made for each pollutant and for purge. Measurements of all constituents shall continue to be taken as long as the test continues, including those constituents for which a decision has already been made.

The fast-pass and fast-fail standards are derived from the Arizona data which included 3,718 tests. Fast-fail standards for each second represent the highest cumulative emission levels in that second obtained for vehicles passing the IM240 using two-ways-to pass criteria (which are more lenient standards than the composite test), based on composite test cutpoints of 0.80 grams per mile (gpm) HC, 15.0 gpm CO, 2.0 gpm NO_x, and 1.0 liter of purge, and Phase 2 cutpoints of 0.50 gpm HC, and 12.0 gpm CO. Hence, vehicles that exceed this level are showing higher cumulative emissions at that point in the test than the dirtiest vehicles passing the full test and therefore fail. Fast-pass standards for each second represent the tenth lowest cumulative emission levels in that second obtained for vehicles failing the IM240 using the two-ways-to-pass criteria. Hence, vehicles that fall below this level are showing lower cumulative emissions at that point in the test than the cleanest vehicles failing the full test and therefore pass. Fast-pass/fast-fail determinations begin at second 30 of the IM240 cycle. The second-by-second standards are depicted in the tables which accompany this description. EPA is continuing to collect data and may revise the standards in the future to further optimize the algorithm.

Beginning at second 94, pass/fail decisions for HC and CO are based upon analysis of cumulative emissions in Phase 2, the portion of the test beginning at second 94, as well as emission levels cumulated from the beginning of the test (the "composite" test). Fast-pass and fast-fail standards are derived for Phase 2 of the test as described above; however, they are used somewhat differently to determine fast-fail conditions. Since we do not have two-ways-to-pass standards for NO_x, there are no Phase 2 NO_x fast-pass/fast-fail standards, and Phase 2 cumulative NO_x emissions are not measured.

The fast-pass/fast-fail algorithm for purge is essentially the same as for tailpipe emissions. Second-by-second cumulative purge levels are compared with second-by-second cumulative purge pass/fail standards. Fast-pass standards correspond to the tenth highest cumulative purge levels for failing vehicles. Fast-fail standards correspond to the lowest cumulative purge levels for passing vehicles. There are no Phase 2 standards for purge.

A vehicle passes the IM240/purge test if the cumulative composite NO_x emissions are below the cumulative composite NO_x fast-pass standard, if cumulative composite purge is above the cumulative composite purge fast-pass standard, and if any of the following four conditions occur:

- cumulative composite emissions of both HC and CO are below the composite fast-pass standards;
- cumulative Phase 2 emissions of both HC and CO are below the Phase 2 fast-pass standards;
- Phase 2 HC emissions are below the Phase 2 HC fast-pass standard and composite CO emissions are below the composite CO fast-pass standard; or
- Phase 2 CO emissions are below the Phase 2 CO fast-pass standard and composite HC emissions are below the composite HC fast-pass standard.

A vehicle fails for a given pollutant prior to second 94 if its cumulative emissions for that pollutant exceed the cumulative composite fast-fail standard. The same failure condition applies for NO_x after second 94. For a vehicle to fast-fail for HC or CO after second 94 two conditions must be satisfied simultaneously: The vehicle's cumulative composite emissions must be above a standard representing the minimum cumulative composite emission level for failing vehicles at the end of the test; and, the vehicle's Phase 2 cumulative emissions must be above a standard representing the maximum cumulative Phase 2 emission level for passing vehicles for the second under consideration.

A vehicle fails for purge if its cumulative composite purge level is below the cumulative composite fast-fail standard. Note that there is no fast-fail standard prior to second 212 of the test. This is because some passing vehicles do not begin purging until this point in the test.

Despite this constraint, EPA's data indicate that average test times using these algorithms are about 115 seconds. A little more than 20 percent of vehicles complete the test at 30 seconds. Fifty percent of vehicles complete the test at or before 120 seconds. By about 180 seconds, 75 percent of vehicles have completed the test, and 95 percent complete the test before 220 seconds.

Terms

Scores

HC_t = cumulative composite HC at time = t seconds
CO_t = cumulative composite CO at time = t seconds
NOx_t = cumulative composite NOx at time = t seconds
P_t = cumulative composite purge at time = t seconds
HC_{bt} = cumulative Phase 2 HC at time = t seconds
CO_{bt} = cumulative Phase 2 CO at time = t seconds
Cumulative composite scores represent the cumulative grams of emissions from t = 0 seconds
Cumulative Phase 2 scores represent the cumulative grams of emissions from t = 94 seconds

Fast-Pass Standards

HC_{pt} = composite HC fast-pass standard at time = t seconds
CO_{pt} = composite CO fast-pass standard at time = t seconds
NOx_{pt} = composite NOx fast-pass standard for failing vehicles at time = t seconds
P_{pt} = composite purge fast-pass standard at time = t seconds
HC_{pbt} = Phase 2 HC fast-pass standard at time = t seconds
CO_{pbt} = Phase 2 CO fast-pass standard at time = t seconds

Fast-Fail Standards

HC_{ft} = composite HC fast-fail standard at time = t seconds
CO_{ft} = composite CO fast-fail standard at time = t seconds
NOx_{ft} = composite NOx fast-fail standard at time = t seconds
P_{ft} = composite purge fast-fail standard at time = t seconds
HC_{ff} = minimum final cumulative composite HC for vehicles failing two-ways-to-pass
CO_{ff} = minimum final cumulative composite CO for vehicles failing two-ways-to-pass
HC_{fbt} = Phase 2 HC fast-fail standard at time = t seconds
CO_{fbt} = Phase 2 CO fast-fail standard at time = t seconds

Fast-Pass Conditions

For $t \geq 30$ seconds, the vehicle shall pass if:

$HC_t < HC_{pt}$ and $CO_t < CO_{pt}$, $NO_{x_t} < NO_{x_{pt}}$; and $P_t > P_{pt}$

additionally, for $t \geq 94$ seconds, the vehicle shall pass if:

$HC_{bt} < HC_{pbt}$ and $CO_{bt} < CO_{pbt}$ $NO_{x_t} < NO_{x_{pt}}$, and $P_t > P_{pt}$, or
$HC_t < HC_{pt}$ and $CO_{bt} < CO_{pbt}$ $NO_{x_t} < NO_{x_{pt}}$, and $P_t > P_{pt}$, or
$HC_{bt} < HC_{pbt}$ and $CO_t < CO_{pt}$ $NO_{x_t} < NO_{x_{pt}}$, and $P_t > P_{pt}$

Fast-Fail Conditions

For $t \geq 30$ seconds, the vehicle shall fail if:

$NO_{x_t} > NO_{x_{ft}}$, and fast-pass or fast-fail conditions have been satisfied for each of the other pollutants and for purge
$P_t < P_{ft}$ and fast-pass or fast-fail conditions have been satisfied for each of the other pollutants

For t = 30 to 93 seconds, the vehicle shall fail if:
$HC_t > HC_{ft}$, and/or $CO_t > CO_{ft}$, and fast-pass or fast-fail conditions have been satisfied for each of the other pollutants and for purge

For $t \geq 94$ seconds, the vehicle shall fail if:
$HC_t > HC_{ff}$ and $HC_{bt} > HC_{fbt}$, and/or $CO_t > CO_{ff}$ and $CO_{bt} > CO_{fbt}$, and fast-pass or fast-fail conditions have been satisfied for each of the other pollutants and for purge

Table 1A: Light-Duty Gasoline Vehicles
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1983-1990

Sec IM 240	HC Fail Composite-2.00/1.25	HC Pass Composite-2.00/1.25	HC Fail Phase 2-2.00/1.25	HC Pass Phase 2-2.00/1.25	CO Fail Composite-30.0/24.0	CO Pass Composite-30.0/24.0	CO Fail Phase 2-30.0/24.0	CO Pass Phase 2-30.0/24.0	NO_x Fail-3.0	NO_x Pass-3.0
30	1.621	0.407	N/A	N/A	30.061	3.804	N/A	N/A	1.422	0.419
31	1.665	0.415	N/A	N/A	30.842	3.985	N/A	N/A	1.453	0.425
32	1.697	0.423	N/A	N/A	31.347	4.215	N/A	N/A	1.510	0.431
33	1.732	0.436	N/A	N/A	31.761	4.440	N/A	N/A	1.585	0.449
34	1.771	0.451	N/A	N/A	32.131	4.579	N/A	N/A	1.658	0.476
35	1.812	0.464	N/A	N/A	32.521	4.688	N/A	N/A	1.717	0.497
36	1.851	0.468	N/A	N/A	33.180	4.749	N/A	N/A	1.760	0.515
37	1.889	0.475	N/A	N/A	34.280	4.783	N/A	N/A	1.792	0.516
38	1.915	0.487	N/A	N/A	35.180	4.813	N/A	N/A	1.817	0.519
39	1.934	0.506	N/A	N/A	36.062	4.876	N/A	N/A	1.836	0.527
40	1.950	0.530	N/A	N/A	36.870	5.104	N/A	N/A	1.852	0.542
41	1.973	0.549	N/A	N/A	37.479	5.217	N/A	N/A	1.866	0.560
42	2.001	0.569	N/A	N/A	38.026	5.383	N/A	N/A	1.875	0.598
43	2.014	0.588	N/A	N/A	38.432	5.571	N/A	N/A	1.883	0.616
44	2.025	0.609	N/A	N/A	38.598	5.888	N/A	N/A	1.909	0.645
45	2.038	0.621	N/A	N/A	38.761	6.199	N/A	N/A	1.960	0.670
46	2.054	0.636	N/A	N/A	38.852	6.245	N/A	N/A	2.014	0.691
47	2.070	0.649	N/A	N/A	38.891	6.318	N/A	N/A	2.056	0.716
48	2.095	0.666	N/A	N/A	38.909	6.418	N/A	N/A	2.092	0.735
49	2.136	0.679	N/A	N/A	38.916	6.540	N/A	N/A	2.133	0.765
50	2.191	0.696	N/A	N/A	38.922	6.690	N/A	N/A	2.178	0.802
51	2.247	0.712	N/A	N/A	38.924	6.875	N/A	N/A	2.219	0.836
52	2.314	0.727	N/A	N/A	38.928	7.029	N/A	N/A	2.252	0.868
53	2.360	0.745	N/A	N/A	38.932	7.129	N/A	N/A	2.275	0.890
54	2.399	0.760	N/A	N/A	38.934	7.359	N/A	N/A	2.288	0.918
55	2.434	0.776	N/A	N/A	38.938	7.722	N/A	N/A	2.294	0.936
56	2.479	0.797	N/A	N/A	38.944	8.017	N/A	N/A	2.296	0.947
57	2.509	0.814	N/A	N/A	39.271	8.249	N/A	N/A	2.336	0.958
58	2.526	0.826	N/A	N/A	39.932	8.425	N/A	N/A	2.397	0.970
59	2.539	0.837	N/A	N/A	40.541	8.563	N/A	N/A	2.452	0.982
60	2.550	0.849	N/A	N/A	41.204	8.686	N/A	N/A	2.501	0.994
61	2.560	0.862	N/A	N/A	41.972	8.804	N/A	N/A	2.541	1.019
62	2.569	0.872	N/A	N/A	42.815	8.916	N/A	N/A	2.570	1.042
63	2.577	0.887	N/A	N/A	43.614	9.025	N/A	N/A	2.589	1.049
64	2.585	0.895	N/A	N/A	44.238	9.138	N/A	N/A	2.602	1.058
65	2.593	0.903	N/A	N/A	44.769	9.250	N/A	N/A	2.612	1.062
66	2.600	0.925	N/A	N/A	45.434	9.354	N/A	N/A	2.622	1.064
67	2.608	0.933	N/A	N/A	46.180	9.457	N/A	N/A	2.637	1.070
68	2.616	0.945	N/A	N/A	46.981	9.575	N/A	N/A	2.657	1.077
69	2.624	0.959	N/A	N/A	47.803	9.728	N/A	N/A	2.684	1.085
70	2.631	0.970	N/A	N/A	48.627	9.938	N/A	N/A	2.716	1.092
71	2.637	0.980	N/A	N/A	49.393	10.140	N/A	N/A	2.751	1.101
72	2.642	0.988	N/A	N/A	50.034	10.222	N/A	N/A	2.789	1.111
73	2.647	0.997	N/A	N/A	50.584	10.261	N/A	N/A	2.831	1.121
74	2.653	1.022	N/A	N/A	51.210	10.278	N/A	N/A	2.872	1.131
75	2.661	1.037	N/A	N/A	51.993	10.290	N/A	N/A	2.907	1.141
76	2.667	1.051	N/A	N/A	52.889	10.715	N/A	N/A	2.933	1.159
77	2.671	1.064	N/A	N/A	53.841	10.790	N/A	N/A	2.951	1.164
78	2.676	1.075	N/A	N/A	54.823	10.844	N/A	N/A	2.969	1.186
79	2.681	1.087	N/A	N/A	55.835	10.921	N/A	N/A	3.000	1.221
80	2.685	1.097	N/A	N/A	56.846	11.010	N/A	N/A	3.054	1.260
81	2.689	1.105	N/A	N/A	57.721	11.090	N/A	N/A	3.126	1.268
82	2.694	1.114	N/A	N/A	58.200	11.136	N/A	N/A	3.205	1.272
83	2.698	1.136	N/A	N/A	58.355	11.136	N/A	N/A	3.279	1.277
84	2.702	1.160	N/A	N/A	58.469	11.165	N/A	N/A	3.341	1.288
85	2.706	1.182	N/A	N/A	58.639	11.191	N/A	N/A	3.387	1.310
86	2.710	1.201	N/A	N/A	58.834	11.205	N/A	N/A	3.417	1.319
87	2.715	1.217	N/A	N/A	59.049	11.211	N/A	N/A	3.436	1.320
88	2.721	1.233	N/A	N/A	59.274	11.211	N/A	N/A	3.449	1.337
89	2.726	1.248	N/A	N/A	59.516	11.211	N/A	N/A	3.458	1.348
90	2.731	1.262	N/A	N/A	59.759	11.211	N/A	N/A	3.465	1.361
91	2.735	1.271	N/A	N/A	59.990	11.220	N/A	N/A	3.471	1.366

92	2.738	1.279	N/A	N/A	60.205	11.294	N/A	N/A	3.476	1.369
93	2.741	1.287	N/A	N/A	60.430	11.332	N/A	N/A	3.481	1.373
94	2.744	1.295	0.026	0.001	60.665	11.355	0.474	0.000	3.486	1.375
95	2.747	1.302	0.088	0.002	60.907	11.383	0.974	0.000	3.491	1.377
96	2.751	1.309	0.135	0.003	61.185	11.410	1.646	0.001	3.497	1.379
97	2.767	1.316	0.159	0.004	61.541	11.433	2.343	0.006	3.503	1.381
98	2.782	1.325	0.188	0.008	62.023	11.516	2.954	0.020	3.509	1.383
99	2.787	1.339	0.213	0.015	62.718	11.820	3.512	0.051	3.515	1.385
100	2.790	1.356	0.234	0.021	63.715	12.104	5.137	0.092	3.522	1.399
101	2.794	1.365	0.265	0.026	64.910	12.344	7.560	0.131	3.530	1.405
102	2.798	1.378	0.288	0.039	65.778	12.781	10.112	0.200	3.541	1.466
103	2.809	1.397	0.308	0.044	66.170	13.472	12.308	0.307	3.559	1.485
104	2.816	1.420	0.329	0.055	66.572	14.405	14.009	0.582	3.589	1.546
105	2.819	1.445	0.343	0.094	67.259	14.808	14.939	0.800	3.626	1.623
106	2.823	1.470	0.354	0.110	67.941	14.965	15.506	0.925	3.658	1.699
107	2.829	1.491	0.386	0.116	68.427	15.121	15.972	0.973	3.685	1.760
108	2.835	1.506	0.410	0.132	68.586	15.372	16.305	1.091	3.711	1.788
109	2.839	1.517	0.427	0.151	68.615	15.530	16.540	1.113	3.732	1.798
110	2.843	1.528	0.443	0.159	68.642	15.687	16.770	1.213	3.746	1.842
111	2.850	1.542	0.461	0.172	68.673	16.018	16.869	1.344	3.755	1.864
112	2.859	1.559	0.469	0.186	68.690	16.527	16.946	1.399	3.760	1.888
113	2.867	1.578	0.491	0.199	68.699	16.810	17.160	1.520	3.763	1.905
114	2.874	1.594	0.538	0.207	68.703	16.961	17.417	1.640	3.768	1.920
115	2.880	1.605	0.562	0.216	68.710	17.120	17.555	1.684	3.778	1.926
116	2.886	1.615	0.575	0.229	68.711	17.135	17.607	1.693	3.790	1.939
117	2.895	1.625	0.584	0.235	68.715	17.249	17.636	1.786	3.801	1.958
118	2.908	1.642	0.592	0.240	68.720	17.451	17.652	2.007	3.809	1.972
119	2.920	1.670	0.599	0.245	68.725	17.509	17.739	2.084	3.813	1.981
120	2.927	1.694	0.610	0.261	68.729	17.605	17.953	2.179	3.815	1.987
121	2.931	1.705	0.620	0.267	68.732	17.734	18.277	2.264	3.817	1.991
122	2.933	1.717	0.635	0.277	68.733	18.049	18.647	2.328	3.819	1.996
123	2.936	1.732	0.652	0.287	68.735	18.447	18.971	2.375	3.822	2.012
124	2.940	1.747	0.668	0.298	68.737	18.592	19.217	2.437	3.826	2.040
125	2.943	1.763	0.682	0.308	68.740	18.657	19.423	2.543	3.831	2.060
126	2.946	1.779	0.694	0.316	68.741	18.796	19.663	2.593	3.836	2.069
127	2.949	1.795	0.706	0.322	68.746	18.952	19.848	2.641	3.840	2.092
128	2.952	1.810	0.716	0.329	68.748	19.137	19.960	2.663	3.844	2.114
129	2.955	1.823	0.725	0.338	68.750	19.329	20.044	2.672	3.847	2.132
130	2.959	1.835	0.734	0.346	68.752	19.519	20.117	2.676	3.849	2.144
131	2.963	1.845	0.743	0.354	68.755	19.707	20.241	2.683	3.850	2.152
132	2.969	1.854	0.752	0.356	68.757	19.882	20.806	2.817	3.851	2.157
133	2.975	1.862	0.761	0.357	68.760	19.905	21.458	2.992	3.852	2.160
134	2.984	1.870	0.772	0.359	68.773	20.049	22.044	3.111	3.853	2.163
135	2.994	1.883	0.779	0.362	68.827	20.460	22.424	3.234	3.854	2.165
136	2.998	1.888	0.798	0.364	68.859	20.746	22.844	3.304	3.856	2.168
137	3.000	1.896	0.822	0.368	68.935	21.068	23.034	3.310	3.859	2.171
138	3.003	1.911	0.880	0.378	69.138	21.380	23.164	3.320	3.865	2.186
139	3.005	1.928	0.903	0.391	69.305	21.748	23.324	3.354	3.876	2.235
140	3.007	1.949	0.922	0.402	69.379	22.046	23.443	3.436	3.892	2.298
141	3.010	1.969	0.937	0.408	69.422	22.348	23.481	3.443	3.911	2.333
142	3.014	1.982	0.950	0.422	69.435	22.397	23.505	3.452	3.937	2.373
143	3.018	1.999	0.961	0.428	69.441	22.407	23.569	3.490	3.970	2.406
144	3.021	2.011	0.969	0.432	69.444	22.417	23.602	3.552	3.998	2.416
145	3.024	2.022	0.974	0.434	69.448	22.922	23.613	3.588	4.015	2.420
146	3.026	2.035	0.978	0.439	69.451	22.951	23.683	3.600	4.024	2.424
147	3.028	2.043	0.984	0.450	69.452	22.976	23.794	3.616	4.029	2.435
148	3.030	2.049	0.990	0.460	69.456	23.017	23.846	3.627	4.033	2.455
149	3.031	2.063	0.994	0.467	69.459	23.073	23.862	3.636	4.039	2.471
150	3.033	2.085	0.997	0.472	69.466	23.161	23.874	3.676	4.047	2.484
151	3.040	2.104	1.000	0.480	69.467	23.218	23.894	3.882	4.054	2.495
152	3.047	2.117	1.003	0.491	69.470	23.253	23.937	4.011	4.058	2.509
153	3.054	2.127	1.008	0.503	69.474	23.337	24.078	4.047	4.061	2.522
154	3.061	2.138	1.022	0.505	69.481	23.425	24.241	4.067	4.064	2.533
155	3.069	2.152	1.030	0.515	69.486	23.534	24.347	4.081	4.069	2.541
156	3.080	2.168	1.039	0.522	69.493	23.652	24.433	4.116	4.074	2.552
157	3.137	2.186	1.049	0.527	69.639	23.739	24.640	4.251	4.078	2.589
158	3.178	2.205	1.055	0.537	70.087	24.606	25.052	5.099	4.080	2.631
159	3.229	2.224	1.063	0.549	70.505	25.615	25.176	5.383	4.084	2.704
160	3.271	2.242	1.070	0.568	71.026	26.073	25.275	6.362	4.102	2.758
161	3.328	2.266	1.085	0.586	71.793	28.496	25.339	7.926	4.150	2.802
162	3.376	2.308	1.095	0.610	72.553	29.772	25.433	8.429	4.212	2.904
163	3.420	2.352	1.121	0.648	73.266	31.056	25.539	9.201	4.267	2.960
164	3.465	2.406	1.140	0.677	73.753	33.351	25.634	10.825	4.314	3.027
165	3.491	2.421	1.153	0.699	74.121	34.890	25.717	12.291	4.357	3.127
166	3.517	2.435	1.165	0.720	74.630	35.937	26.037	13.366	4.403	3.187

167	3.548	2.470	1.177	0.738	74.956	37.012	26.305	14.428	4.474	3.306
168	3.585	2.501	1.191	0.767	75.297	37.892	26.350	15.318	4.539	3.384
169	3.626	2.537	1.228	0.828	75.928	39.028	26.417	15.699	4.598	3.467
170	3.679	2.571	1.248	0.855	76.740	40.406	27.743	16.073	4.658	3.565
171	3.716	2.625	1.262	0.869	77.353	41.379	28.496	16.475	4.719	3.640
172	3.738	2.657	1.272	0.885	77.684	42.033	28.713	17.158	4.770	3.718
173	3.753	2.683	1.280	0.900	77.825	42.432	28.757	17.532	4.806	3.781
174	3.764	2.701	1.290	0.941	77.861	42.742	28.773	17.965	4.829	3.827
175	3.774	2.717	1.305	0.979	77.870	43.399	28.786	18.242	4.843	3.852
176	3.782	2.732	1.321	1.002	77.873	43.895	28.798	18.283	4.855	3.903
177	3.793	2.756	1.338	1.025	77.879	44.227	28.823	18.480	4.871	3.930
178	3.800	2.781	1.356	1.047	77.883	44.926	28.914	19.576	4.893	3.970
179	3.807	2.811	1.375	1.065	77.932	45.256	28.967	20.015	4.917	4.015
180	3.815	2.853	1.395	1.089	78.158	45.553	28.983	20.203	4.936	4.074
181	3.822	2.898	1.416	1.109	78.507	45.753	28.991	20.433	4.948	4.159
182	3.828	2.946	1.437	1.133	79.057	46.210	29.004	21.025	4.955	4.230
183	3.833	2.988	1.459	1.158	79.568	47.017	29.108	21.882	5.006	4.286
184	3.839	3.023	1.485	1.184	79.891	48.185	29.443	22.204	5.071	4.334
185	3.844	3.057	1.509	1.209	80.242	48.741	29.843	22.859	5.151	4.388
186	3.849	3.076	1.519	1.222	80.839	49.462	29.999	23.533	5.216	4.447
187	3.856	3.101	1.525	1.231	81.590	50.313	30.034	24.281	5.244	4.505
188	3.861	3.120	1.530	1.239	82.220	51.285	30.074	25.078	5.257	4.561
189	3.865	3.136	1.534	1.254	82.669	52.076	30.130	25.276	5.270	4.625
190	3.873	3.151	1.537	1.278	82.954	52.857	30.517	25.578	5.290	4.696
191	3.880	3.163	1.539	1.300	83.104	52.876	30.831	25.859	5.312	4.731
192	3.886	3.209	1.541	1.313	83.207	53.067	30.905	25.985	5.334	4.780
193	3.892	3.223	1.544	1.324	83.385	53.777	30.955	26.153	5.358	4.837
194	3.897	3.237	1.547	1.340	83.643	54.242	31.033	26.582	5.385	4.876
195	3.902	3.263	1.550	1.367	83.983	54.489	31.076	27.067	5.411	4.928
196	3.906	3.302	1.553	1.387	84.312	54.601	31.089	27.456	5.440	4.972
197	3.910	3.338	1.556	1.402	84.682	54.912	31.092	27.805	5.470	5.025
198	3.917	3.372	1.559	1.417	85.036	55.588	31.095	28.070	5.504	5.104
199	3.924	3.390	1.562	1.432	85.208	56.266	31.107	28.590	5.539	5.189
200	3.929	3.428	1.565	1.446	85.249	56.617	31.164	28.914	5.567	5.275
201	3.933	3.470	1.568	1.460	85.262	56.863	31.201	29.063	5.588	5.336
202	3.947	3.493	1.571	1.477	85.267	57.204	31.209	29.502	5.599	5.366
203	3.959	3.509	1.573	1.492	85.271	57.371	31.222	29.697	5.604	5.387
204	3.966	3.522	1.575	1.501	85.275	57.487	31.411	29.713	5.607	5.427
205	3.975	3.533	1.576	1.510	85.280	57.728	31.517	29.783	5.608	5.444
206	3.986	3.550	1.582	1.522	85.298	58.097	31.570	29.942	5.610	5.447
207	3.991	3.578	1.593	1.561	85.317	58.572	31.596	30.284	5.618	5.477
208	3.995	3.607	1.604	1.585	85.332	59.024	31.694	30.755	5.636	5.520
209	3.999	3.630	1.615	1.597	85.409	59.321	31.988	31.287	5.664	5.560
210	4.002	3.658	1.624	1.607	85.562	59.715	32.299	31.549	5.692	5.603
211	4.005	3.701	1.635	1.627	85.908	60.045	32.622	31.820	5.727	5.657
212	4.008	3.745	1.647	1.645	86.430	60.453	32.749	32.250	5.782	5.698
213	4.011	3.778	1.658	1.656	86.854	60.935	32.879	32.546	5.813	5.762
214	4.014	3.814	1.669	1.663	87.154	61.307	32.999	32.808	5.827	5.836
215	4.018	3.825	1.678	1.669	87.440	61.666	33.060	33.142	5.849	5.944
216	4.021	3.835	1.686	1.674	87.745	62.148	33.204	33.529	5.884	6.008
217	4.024	3.844	1.694	1.685	87.897	62.532	33.341	33.763	5.908	6.040
218	4.027	3.853	1.700	1.705	87.927	62.546	33.414	33.921	5.921	6.072
219	4.031	3.864	1.704	1.711	87.935	62.559	33.514	33.961	5.931	6.089
220	4.035	3.874	1.706	1.735	87.938	62.570	33.640	33.983	5.939	6.101
221	4.038	3.891	1.709	1.752	87.942	62.846	33.692	34.007	5.947	6.118
222	4.041	3.928	1.711	1.760	87.944	63.097	33.711	34.032	5.952	6.126
223	4.044	3.966	1.714	1.774	87.947	63.150	33.733	34.054	5.955	6.139
224	4.047	4.008	1.718	1.778	87.948	63.150	33.770	34.061	5.957	6.145
225	4.052	4.010	1.721	1.797	87.952	63.150	33.796	34.082	5.959	6.148
226	4.057	4.012	1.723	1.802	87.954	63.150	33.810	34.100	5.961	6.150
227	4.060	4.016	1.726	1.804	87.957	63.150	33.821	34.109	5.963	6.151
228	4.064	4.019	1.729	1.806	87.960	63.150	33.839	34.129	5.966	6.152
229	4.067	4.057	1.731	1.810	87.964	63.150	33.865	34.284	5.971	6.153
230	4.069	4.065	1.733	1.814	87.968	63.150	33.894	34.397	5.977	6.154
231	4.071	4.072	1.735	1.827	87.971	63.150	33.918	34.463	5.984	6.156
232	4.073	4.081	1.743	1.833	87.971	63.150	33.944	34.465	5.990	6.157
233	4.075	4.104	1.749	1.837	87.974	63.150	33.985	34.466	5.997	6.159
234	4.077	4.124	1.753	1.841	87.974	63.153	34.014	34.468	6.004	6.160
235	4.079	4.128	1.757	1.845	87.978	63.159	34.032	34.470	6.012	6.162
236	4.081	4.132	1.762	1.851	87.980	63.173	34.051	34.471	6.024	6.163
237	4.083	4.137	1.767	1.855	87.985	63.193	34.067	34.472	6.037	6.164
238	4.084	4.147	1.772	1.857	87.987	63.214	34.079	34.472	6.049	6.166
239	4.085	4.158	1.776	1.860	87.991	63.233	34.085	34.473	6.060	6.168

Table 1B: Light-Duty Gasoline Vehicles
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1991-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

Sec IM 240	HC Fail Composite-1.25/0.75	HC Pass Composite-1.25/0.75	HC Fail Phase 2-1.25/0.75	HC Pass Phase 2-1.25/0.75	CO Fail Composite-20.0/16.0	CO Pass Composite-20.0/16.0	CO Fail Phase 2-20.0/16.0	CO Pass Phase 2-20.0/16.0	NO_x Fail-2.5	NO_x Pass-2.5
30	1.193	0.247	N/A	N/A	20.563	1.502	N/A	N/A	1.422	0.262
31	1.207	0.253	N/A	N/A	21.487	1.546	N/A	N/A	1.453	0.275
32	1.221	0.258	N/A	N/A	22.382	1.568	N/A	N/A	1.510	0.301
33	1.234	0.263	N/A	N/A	22.997	1.582	N/A	N/A	1.585	0.317
34	1.246	0.268	N/A	N/A	23.355	1.593	N/A	N/A	1.658	0.327
35	1.258	0.277	N/A	N/A	23.663	1.602	N/A	N/A	1.717	0.330
36	1.270	0.283	N/A	N/A	23.946	1.621	N/A	N/A	1.760	0.332
37	1.281	0.293	N/A	N/A	24.204	1.631	N/A	N/A	1.792	0.334
38	1.292	0.297	N/A	N/A	24.637	1.702	N/A	N/A	1.817	0.336
39	1.303	0.298	N/A	N/A	25.522	1.784	N/A	N/A	1.836	0.337
40	1.313	0.313	N/A	N/A	26.535	1.879	N/A	N/A	1.852	0.354
41	1.323	0.320	N/A	N/A	27.547	2.162	N/A	N/A	1.866	0.366
42	1.332	0.327	N/A	N/A	28.745	2.307	N/A	N/A	1.875	0.410
43	1.341	0.342	N/A	N/A	29.937	2.343	N/A	N/A	1.883	0.414
44	1.350	0.360	N/A	N/A	30.606	2.376	N/A	N/A	1.909	0.438
45	1.359	0.376	N/A	N/A	30.909	2.406	N/A	N/A	1.960	0.477
46	1.367	0.389	N/A	N/A	31.209	2.433	N/A	N/A	2.014	0.506
47	1.375	0.408	N/A	N/A	31.695	2.458	N/A	N/A	2.056	0.518
48	1.383	0.423	N/A	N/A	32.575	2.483	N/A	N/A	2.092	0.522
49	1.390	0.434	N/A	N/A	33.560	2.774	N/A	N/A	2.133	0.526
50	1.397	0.444	N/A	N/A	34.500	2.844	N/A	N/A	2.176	0.554
51	1.404	0.454	N/A	N/A	35.378	2.900	N/A	N/A	2.219	0.574
52	1.411	0.465	N/A	N/A	36.105	2.936	N/A	N/A	2.252	0.587
53	1.417	0.472	N/A	N/A	36.809	3.133	N/A	N/A	2.275	0.601
54	1.423	0.478	N/A	N/A	37.446	3.304	N/A	N/A	2.288	0.615
55	1.429	0.485	N/A	N/A	37.998	3.407	N/A	N/A	2.294	0.629
56	1.435	0.493	N/A	N/A	38.503	3.456	N/A	N/A	2.296	0.643
57	1.441	0.500	N/A	N/A	38.962	3.480	N/A	N/A	2.297	0.667
58	1.447	0.505	N/A	N/A	39.353	3.518	N/A	N/A	2.298	0.678
59	1.452	0.514	N/A	N/A	39.750	3.560	N/A	N/A	2.299	0.683
60	1.457	0.537	N/A	N/A	40.193	3.593	N/A	N/A	2.300	0.686
61	1.462	0.540	N/A	N/A	40.648	3.628	N/A	N/A	2.301	0.689
62	1.467	0.543	N/A	N/A	41.103	3.641	N/A	N/A	2.304	0.699
63	1.472	0.546	N/A	N/A	41.524	3.655	N/A	N/A	2.310	0.703
64	1.477	0.551	N/A	N/A	41.840	3.680	N/A	N/A	2.318	0.707
65	1.482	0.559	N/A	N/A	42.097	3.700	N/A	N/A	2.321	0.711
66	1.487	0.567	N/A	N/A	42.360	3.728	N/A	N/A	2.327	0.716
67	1.492	0.575	N/A	N/A	42.707	3.857	N/A	N/A	2.333	0.721
68	1.497	0.588	N/A	N/A	43.158	3.894	N/A	N/A	2.337	0.726
69	1.502	0.595	N/A	N/A	43.551	3.943	N/A	N/A	2.366	0.742
70	1.507	0.601	N/A	N/A	43.845	3.983	N/A	N/A	2.418	0.759
71	1.511	0.606	N/A	N/A	44.085	4.009	N/A	N/A	2.462	0.773
72	1.515	0.610	N/A	N/A	44.293	4.023	N/A	N/A	2.484	0.784
73	1.519	0.617	N/A	N/A	44.423	4.023	N/A	N/A	2.492	0.790
74	1.523	0.631	N/A	N/A	44.545	4.053	N/A	N/A	2.496	0.794
75	1.527	0.643	N/A	N/A	44.792	4.063	N/A	N/A	2.507	0.799
76	1.531	0.651	N/A	N/A	45.292	4.077	N/A	N/A	2.534	0.809
77	1.535	0.659	N/A	N/A	45.734	4.225	N/A	N/A	2.575	0.821
78	1.539	0.667	N/A	N/A	45.977	4.243	N/A	N/A	2.636	0.833
79	1.543	0.676	N/A	N/A	46.165	4.260	N/A	N/A	2.711	0.839
80	1.547	0.681	N/A	N/A	46.395	4.282	N/A	N/A	2.787	0.844
81	1.551	0.685	N/A	N/A	46.540	4.322	N/A	N/A	2.843	0.857
82	1.555	0.689	N/A	N/A	46.619	4.398	N/A	N/A	2.872	0.870
83	1.559	0.694	N/A	N/A	46.692	4.482	N/A	N/A	2.885	0.883
84	1.562	0.700	N/A	N/A	46.754	4.515	N/A	N/A	2.890	0.894
85	1.565	0.705	N/A	N/A	46.810	4.518	N/A	N/A	2.893	0.902
86	1.568	0.709	N/A	N/A	46.866	4.520	N/A	N/A	2.895	0.907
87	1.571	0.713	N/A	N/A	46.918	4.522	N/A	N/A	2.896	0.910
88	1.574	0.717	N/A	N/A	46.966	4.522	N/A	N/A	2.897	0.912
89	1.577	0.721	N/A	N/A	47.007	4.523	N/A	N/A	2.898	0.913
90	1.580	0.724	N/A	N/A	47.043	4.526	N/A	N/A	2.899	0.914
91	1.583	0.727	N/A	N/A	47.076	4.527	N/A	N/A	2.900	0.915
92	1.586	0.729	N/A	N/A	47.105	4.527	N/A	N/A	2.901	0.916
93	1.589	0.731	N/A	N/A	47.133	4.528	N/A	N/A	2.902	0.917
94	1.592	0.734	0.017	0.000	47.163	4.528	0.474	0.000	2.902	0.918
95	1.594	0.740	0.066	0.000	47.197	4.528	0.974	0.000	2.902	0.919
96	1.596	0.748	0.107	0.001	47.270	4.529	1.646	0.000	2.902	0.920

97	1.599	0.759	0.159	0.001	47.555	4.575	2.343	0.000	2.902	0.921
98	1.602	0.771	0.188	0.002	48.132	4.703	2.954	0.002	2.902	0.922
99	1.605	0.783	0.213	0.003	48.596	4.805	3.512	0.005	2.903	0.924
100	1.608	0.793	0.234	0.005	48.867	4.886	3.942	0.010	2.912	0.929
101	1.611	0.810	0.265	0.007	49.466	4.957	4.477	0.017	2.942	0.941
102	1.628	0.823	0.288	0.009	50.233	5.104	5.050	0.052	2.978	0.970
103	1.645	0.836	0.308	0.011	50.655	5.340	5.577	0.085	3.029	1.027
104	1.657	0.853	0.329	0.016	50.922	5.496	6.008	0.094	3.063	1.093
105	1.666	0.871	0.343	0.017	51.076	5.625	6.826	0.122	3.089	1.155
106	1.674	0.887	0.350	0.022	51.124	5.815	7.503	0.151	3.150	1.234
107	1.684	0.899	0.365	0.029	51.169	6.473	8.101	0.191	3.195	1.275
108	1.693	0.931	0.379	0.036	51.695	7.037	8.627	0.234	3.218	1.305
109	1.702	0.947	0.389	0.040	52.230	7.419	9.162	0.246	3.230	1.320
110	1.712	0.957	0.395	0.047	52.746	7.643	9.678	0.257	3.237	1.332
111	1.723	0.965	0.400	0.052	53.122	7.759	10.054	0.286	3.245	1.346
112	1.750	0.971	0.403	0.056	53.586	7.824	10.518	0.379	3.269	1.358
113	1.786	0.977	0.405	0.061	54.077	7.889	11.009	0.425	3.296	1.378
114	1.813	0.983	0.408	0.064	54.467	7.960	11.399	0.457	3.311	1.406
115	1.829	1.003	0.410	0.072	54.801	8.024	11.733	0.477	3.317	1.426
116	1.840	1.030	0.419	0.081	55.058	8.076	11.990	0.494	3.322	1.438
117	1.853	1.041	0.432	0.082	55.341	8.111	12.273	0.504	3.324	1.448
118	1.869	1.050	0.448	0.083	55.615	8.130	12.547	0.512	3.326	1.460
119	1.885	1.052	0.464	0.092	55.781	8.148	12.713	0.519	3.328	1.462
120	1.904	1.055	0.483	0.094	55.956	8.211	12.888	0.529	3.330	1.467
121	1.941	1.061	0.520	0.097	56.039	8.478	12.971	0.529	3.336	1.476
122	1.979	1.071	0.558	0.100	56.100	8.548	13.032	0.530	3.346	1.494
123	2.006	1.081	0.585	0.103	56.177	8.561	13.109	0.531	3.362	1.505
124	2.023	1.091	0.602	0.106	56.212	8.568	13.144	0.532	3.378	1.517
125	2.034	1.102	0.613	0.108	56.220	8.572	13.152	0.533	3.389	1.546
126	2.041	1.110	0.620	0.110	56.245	8.584	13.177	0.548	3.396	1.569
127	2.046	1.116	0.625	0.112	56.348	8.592	13.280	0.610	3.400	1.586
128	2.050	1.121	0.629	0.114	56.480	8.596	13.412	0.614	3.403	1.596
129	2.054	1.125	0.633	0.116	56.588	8.597	13.520	0.622	3.404	1.603
130	2.058	1.128	0.637	0.118	56.678	8.601	13.610	0.631	3.405	1.605
131	2.063	1.130	0.642	0.120	56.765	8.605	13.697	0.640	3.405	1.606
132	2.067	1.132	0.646	0.122	56.881	8.608	13.813	0.646	3.406	1.607
133	2.070	1.134	0.649	0.123	57.070	8.626	14.002	0.650	3.406	1.607
134	2.073	1.135	0.652	0.124	57.169	8.650	14.101	0.652	3.406	1.608
135	2.075	1.143	0.654	0.127	57.192	8.660	14.124	0.738	3.410	1.614
136	2.078	1.147	0.657	0.130	57.199	8.767	14.131	0.754	3.429	1.616
137	2.083	1.156	0.662	0.134	57.209	9.029	14.141	0.780	3.460	1.631
138	2.087	1.163	0.666	0.139	57.218	9.238	14.150	0.795	3.493	1.643
139	2.091	1.186	0.670	0.146	57.219	9.389	14.151	0.804	3.517	1.656
140	2.095	1.253	0.674	0.149	57.227	9.493	14.159	0.810	3.535	1.673
141	2.098	1.262	0.677	0.151	57.290	9.583	14.222	0.815	3.545	1.703
142	2.101	1.271	0.680	0.153	57.378	9.626	14.310	0.818	3.558	1.739
143	2.105	1.277	0.684	0.155	57.434	9.669	14.366	0.821	3.577	1.767
144	2.110	1.283	0.689	0.157	57.453	9.716	14.385	0.825	3.590	1.774
145	2.114	1.291	0.693	0.162	57.458	9.763	14.390	0.840	3.604	1.785
146	2.117	1.294	0.696	0.164	57.458	9.809	14.390	0.847	3.617	1.806
147	2.119	1.296	0.698	0.166	57.458	9.952	14.390	0.855	3.625	1.830
148	2.121	1.298	0.700	0.168	57.470	9.885	14.402	0.865	3.629	1.844
149	2.123	1.303	0.702	0.169	57.536	9.932	14.468	0.874	3.632	1.845
150	2.125	1.316	0.704	0.170	57.609	9.986	14.541	0.891	3.633	1.846
151	2.127	1.330	0.706	0.171	57.665	10.039	14.597	0.914	3.635	1.852
152	2.129	1.342	0.708	0.172	57.699	10.072	14.631	0.929	3.637	1.868
153	2.131	1.348	0.710	0.173	57.712	10.090	14.644	0.937	3.640	1.877
154	2.133	1.353	0.712	0.175	57.714	10.105	14.646	0.942	3.644	1.879
155	2.134	1.362	0.713	0.178	57.714	10.146	14.646	0.949	3.646	1.886
156	2.135	1.365	0.714	0.180	57.913	10.245	14.848	1.375	3.649	1.900
157	2.136	1.366	0.715	0.189	58.241	10.397	14.932	1.576	3.655	1.910
158	2.138	1.373	0.717	0.198	58.916	10.923	14.949	1.943	3.678	1.936
159	2.140	1.397	0.719	0.203	60.120	11.970	15.901	2.820	3.719	1.954
160	2.142	1.423	0.721	0.207	60.940	13.421	17.261	3.281	3.779	1.986
161	2.145	1.440	0.724	0.214	61.396	15.289	17.854	3.483	3.854	2.050
162	2.149	1.452	0.728	0.221	61.655	15.912	17.988	3.620	3.921	2.131
163	2.154	1.465	0.736	0.229	61.864	16.530	18.046	4.168	3.960	2.235
164	2.159	1.509	0.743	0.247	62.194	17.622	18.133	4.338	3.998	2.320
165	2.164	1.533	0.750	0.274	62.455	18.366	18.179	4.682	4.041	2.395
166	2.169	1.555	0.756	0.309	62.675	19.869	18.233	5.633	4.091	2.488
167	2.175	1.576	0.783	0.318	62.876	20.711	18.558	6.137	4.144	2.563
168	2.181	1.598	0.810	0.322	63.051	22.319	20.062	6.853	4.187	2.645
169	2.187	1.618	0.827	0.333	63.178	23.751	20.978	7.136	4.227	2.746
170	2.193	1.636	0.836	0.343	63.231	24.842	21.211	7.320	4.261	2.778
171	2.199	1.666	0.843	0.356	63.300	25.410	21.267	7.685	4.288	2.792

172	2.205	1.685	0.851	0.385	63.525	25.798	21.288	8.052	4.303	2.810
173	2.211	1.726	0.857	0.409	63.766	26.122	21.298	8.344	4.309	2.847
174	2.217	1.742	0.861	0.433	63.912	26.353	21.305	8.602	4.314	2.874
175	2.222	1.756	0.864	0.453	64.046	26.638	21.320	8.898	4.321	2.905
176	2.226	1.769	0.867	0.463	64.188	27.219	21.384	9.251	4.329	2.950
177	2.230	1.784	0.870	0.507	64.315	27.279	21.428	10.253	4.340	3.001
178	2.234	1.802	0.875	0.523	64.432	27.320	21.442	10.828	4.352	3.047
179	2.238	1.822	0.882	0.528	64.553	27.352	21.447	10.933	4.363	3.104
180	2.241	1.843	0.886	0.541	64.683	27.822	21.451	11.060	4.376	3.173
181	2.244	1.864	0.890	0.549	64.819	28.763	21.455	11.188	4.393	3.238
182	2.247	1.884	0.893	0.559	64.963	29.402	21.460	11.345	4.409	3.302
183	2.250	1.896	0.896	0.571	65.123	29.971	21.464	11.733	4.430	3.372
184	2.253	1.915	0.899	0.584	65.296	30.276	21.469	12.598	4.455	3.452
185	2.256	1.940	0.902	0.598	65.466	30.988	21.473	12.953	4.483	3.545
186	2.260	1.958	0.905	0.613	65.586	31.095	21.477	13.213	4.510	3.648
187	2.264	1.972	0.908	0.624	65.670	31.314	21.482	14.131	4.532	3.701
188	2.268	1.985	0.910	0.629	65.743	31.833	21.485	14.839	4.551	3.759
189	2.273	1.991	0.914	0.629	65.817	32.239	21.488	15.137	4.563	3.821
190	2.284	1.993	0.916	0.638	65.899	32.547	21.491	15.138	4.572	3.870
191	2.298	1.995	0.918	0.648	65.999	32.855	21.494	15.141	4.580	3.892
192	2.307	2.001	0.920	0.659	66.117	33.153	21.512	15.595	4.588	3.914
193	2.313	2.015	0.921	0.663	66.236	33.444	21.533	15.658	4.597	3.955
194	2.317	2.031	0.923	0.671	66.345	33.482	21.541	15.704	4.607	3.997
195	2.321	2.047	0.926	0.681	66.453	33.516	21.545	15.729	4.618	4.035
196	2.324	2.063	0.946	0.693	66.565	33.549	21.550	16.058	4.629	4.089
197	2.327	2.079	0.961	0.709	66.680	33.653	21.556	16.987	4.641	4.146
198	2.330	2.094	0.969	0.725	66.782	33.973	21.559	17.064	4.653	4.206
199	2.334	2.109	0.975	0.740	66.857	34.159	21.563	17.073	4.667	4.243
200	2.337	2.122	0.978	0.754	66.910	34.191	21.567	17.153	4.681	4.295
201	2.340	2.130	0.982	0.767	66.958	34.250	21.571	17.332	4.694	4.351
202	2.343	2.137	0.984	0.775	66.989	34.469	21.575	17.406	4.703	4.398
203	2.346	2.157	0.986	0.787	67.007	34.716	21.587	17.641	4.708	4.410
204	2.349	2.172	0.988	0.795	67.017	34.969	21.607	17.922	4.710	4.419
205	2.352	2.194	0.990	0.803	67.055	35.144	21.635	18.484	4.711	4.426
206	2.354	2.222	0.992	0.854	67.392	35.418	21.655	18.553	4.716	4.429
207	2.356	2.245	0.994	0.859	67.905	35.766	21.699	18.658	4.734	4.453
208	2.358	2.268	0.996	0.872	68.219	35.949	21.848	18.953	4.756	4.486
209	2.360	2.279	0.997	0.892	68.363	36.010	21.981	19.266	4.770	4.542
210	2.362	2.288	0.999	0.896	68.477	36.548	22.044	19.309	4.782	4.598
211	2.366	2.301	1.005	0.903	68.592	37.179	22.169	19.731	4.794	4.638
212	2.372	2.316	1.009	0.924	68.711	37.651	22.284	19.902	4.805	4.715
213	2.377	2.332	1.018	0.938	68.829	38.041	22.382	20.012	4.821	4.774
214	2.381	2.345	1.030	0.941	68.924	38.591	22.457	20.260	4.861	4.829
215	2.385	2.354	1.033	0.951	69.000	38.852	22.499	20.739	4.920	4.872
216	2.388	2.362	1.035	0.966	69.063	38.861	22.514	21.346	4.951	4.931
217	2.391	2.368	1.036	0.979	69.115	38.926	22.571	21.810	4.960	4.981
218	2.394	2.376	1.037	0.980	69.160	39.194	22.613	22.001	4.963	5.017
219	2.397	2.384	1.038	0.981	69.194	39.474	22.625	22.290	4.965	5.029
220	2.400	2.391	1.040	1.005	69.222	39.668	22.637	22.324	4.968	5.033
221	2.404	2.395	1.044	1.016	69.241	39.781	22.647	22.343	4.971	5.037
222	2.407	2.400	1.047	1.022	69.251	39.890	22.655	22.522	4.974	5.047
223	2.410	2.405	1.052	1.028	69.261	39.954	22.661	22.683	4.977	5.057
224	2.412	2.409	1.058	1.035	69.269	39.984	22.666	22.850	4.979	5.061
225	2.414	2.413	1.060	1.041	69.278	39.989	22.667	22.853	4.980	5.062
226	2.415	2.417	1.060	1.045	69.302	39.990	22.668	22.853	4.981	5.063
227	2.417	2.426	1.061	1.051	69.335	39.990	22.669	22.853	4.982	5.063
228	2.419	2.428	1.062	1.055	69.364	39.990	22.670	22.872	4.983	5.063
229	2.420	2.431	1.062	1.059	69.389	39.991	22.671	22.872	4.984	5.063
230	2.421	2.433	1.062	1.064	69.411	40.012	22.671	22.872	4.985	5.064
231	2.423	2.441	1.063	1.069	69.429	40.061	22.672	22.895	4.986	5.065
232	2.425	2.461	1.063	1.071	69.443	40.116	22.673	22.911	4.987	5.066
233	2.427	2.476	1.063	1.072	69.455	40.249	22.673	22.922	4.988	5.067
234	2.429	2.488	1.064	1.073	69.466	40.253	22.673	22.939	4.989	5.068
235	2.430	2.498	1.064	1.081	69.473	40.290	22.674	23.010	4.990	5.069
236	2.431	2.508	1.066	1.083	69.481	40.385	22.675	23.010	4.991	5.070
237	2.432	2.516	1.069	1.084	69.487	40.488	22.675	23.010	4.992	5.070
238	2.433	2.520	1.072	1.085	69.496	40.720	22.675	23.010	4.993	5.070
239	2.434	2.523	1.075	1.086	69.504	40.763	22.677	23.010	4.994	5.070

Table 1C: Light-Duty Gasoline Vehicles
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1991-1995 certified to Tier 1 standards and all 1996 and newer vehicles

SECS IM240	HC Fail Composite	HC Pass Composite	HC Fail Phase 2	HC Pass Phase 2	CO Fail Composite	CO Pass Composite	CO Fail Phase 2	CO Pass Phase 2	NO Fail	NO Pass
30	>1.193	<0.124	N/A	N/A	>16.540	< 0.693	N/A	N/A	>1.422	<0.167
31	>1.207	<0.126	N/A	N/A	>17.419	< 0.773	N/A	N/A	>1.453	<0.177
32	>1.221	<0.129	N/A	N/A	>18.132	< 0.837	N/A	N/A	>1.510	<0.188
33	>1.234	<0.135	N/A	N/A	>18.601	< 0.851	N/A	N/A	>1.585	<0.214
34	>1.246	<0.140	N/A	N/A	>18.846	< 0.853	N/A	N/A	>1.658	<0.232
35	>1.258	<0.146	N/A	N/A	>18.993	< 0.857	N/A	N/A	>1.717	<0.240
36	>1.270	<0.150	N/A	N/A	>19.083	< 0.900	N/A	N/A	>1.760	<0.243
37	>1.281	<0.153	N/A	N/A	>19.136	< 0.960	N/A	N/A	>1.792	<0.245
38	>1.292	<0.156	N/A	N/A	>19.169	< 1.034	N/A	N/A	>1.817	<0.246
39	>1.303	<0.160	N/A	N/A	>19.196	< 1.070	N/A	N/A	>1.836	<0.246
40	>1.313	<0.165	N/A	N/A	>19.227	< 1.076	N/A	N/A	>1.852	<0.250
41	>1.323	<0.169	N/A	N/A	>19.288	< 1.083	N/A	N/A	>1.866	<0.260
42	>1.332	<0.172	N/A	N/A	>19.376	< 1.102	N/A	N/A	>1.875	<0.277
43	>1.341	<0.173	N/A	N/A	>19.465	< 1.111	N/A	N/A	>1.883	<0.311
44	>1.350	<0.177	N/A	N/A	>19.522	< 1.114	N/A	N/A	>1.909	<0.328
45	>1.359	<0.197	N/A	N/A	>19.590	< 1.157	N/A	N/A	>1.960	<0.343
46	>1.367	<0.200	N/A	N/A	>19.647	< 1.344	N/A	N/A	>2.014	<0.359
47	>1.375	<0.208	N/A	N/A	>19.678	< 1.482	N/A	N/A	>2.056	<0.373
48	>1.383	<0.221	N/A	N/A	>19.695	< 1.530	N/A	N/A	>2.092	<0.383
49	>1.390	<0.232	N/A	N/A	>19.727	< 1.542	N/A	N/A	>2.133	<0.385
50	>1.397	<0.235	N/A	N/A	>20.011	< 1.553	N/A	N/A	>2.178	<0.400
51	>1.404	<0.238	N/A	N/A	>20.510	< 1.571	N/A	N/A	>2.219	<0.410
52	>1.411	<0.240	N/A	N/A	>21.038	< 1.595	N/A	N/A	>2.252	<0.434
53	>1.417	<0.242	N/A	N/A	>21.587	< 1.633	N/A	N/A	>2.275	<0.464
54	>1.423	<0.246	N/A	N/A	>22.148	< 1.685	N/A	N/A	>2.288	<0.472
55	>1.429	<0.249	N/A	N/A	>22.728	< 1.689	N/A	N/A	>2.294	<0.480
56	>1.435	<0.252	N/A	N/A	>23.312	< 1.693	N/A	N/A	>2.296	<0.491
57	>1.441	<0.261	N/A	N/A	>23.869	< 1.700	N/A	N/A	>2.297	<0.500
58	>1.447	<0.271	N/A	N/A	>24.389	< 1.723	N/A	N/A	>2.298	<0.506
59	>1.452	<0.276	N/A	N/A	>24.845	< 1.852	N/A	N/A	>2.299	<0.509
60	>1.457	<0.278	N/A	N/A	>25.217	< 1.872	N/A	N/A	>2.300	<0.512
61	>1.462	<0.280	N/A	N/A	>25.554	< 1.872	N/A	N/A	>2.301	<0.516
62	>1.467	<0.282	N/A	N/A	>25.826	< 1.872	N/A	N/A	>2.304	<0.519
63	>1.472	<0.283	N/A	N/A	>25.973	< 1.900	N/A	N/A	>2.310	<0.523
64	>1.477	<0.284	N/A	N/A	>26.037	< 1.917	N/A	N/A	>2.315	<0.529
65	>1.482	<0.285	N/A	N/A	>26.082	< 1.944	N/A	N/A	>2.320	<0.533
66	>1.487	<0.286	N/A	N/A	>26.122	< 2.000	N/A	N/A	>2.327	<0.535
67	>1.492	<0.288	N/A	N/A	>26.148	< 2.060	N/A	N/A	>2.333	<0.540
68	>1.497	<0.291	N/A	N/A	>26.161	< 2.064	N/A	N/A	>2.337	<0.551
69	>1.502	<0.294	N/A	N/A	>26.168	< 2.076	N/A	N/A	>2.339	<0.563
70	>1.507	<0.296	N/A	N/A	>26.186	< 2.104	N/A	N/A	>2.340	<0.575
71	>1.511	<0.298	N/A	N/A	>26.277	< 2.117	N/A	N/A	>2.341	<0.588
72	>1.515	<0.300	N/A	N/A	>26.414	< 2.125	N/A	N/A	>2.342	<0.600
73	>1.519	<0.302	N/A	N/A	>26.507	< 2.130	N/A	N/A	>2.342	<0.603
74	>1.523	<0.304	N/A	N/A	>26.550	< 2.138	N/A	N/A	>2.342	<0.604
75	>1.527	<0.307	N/A	N/A	>26.568	< 2.152	N/A	N/A	>2.342	<0.613
76	>1.531	<0.308	N/A	N/A	>26.570	< 2.170	N/A	N/A	>2.342	<0.624
77	>1.535	<0.308	N/A	N/A	>26.570	< 2.188	N/A	N/A	>2.342	<0.646
78	>1.539	<0.308	N/A	N/A	>27.042	< 2.200	N/A	N/A	>2.342	<0.651
79	>1.543	<0.314	N/A	N/A	>27.456	< 2.212	N/A	N/A	>2.342	<0.659
80	>1.547	<0.320	N/A	N/A	>27.716	< 2.212	N/A	N/A	>2.342	<0.673
81	>1.551	<0.324	N/A	N/A	>27.941	< 2.221	N/A	N/A	>2.342	<0.696
82	>1.555	<0.327	N/A	N/A	>28.110	< 2.222	N/A	N/A	>2.342	<0.706
83	>1.559	<0.329	N/A	N/A	>28.270	< 2.227	N/A	N/A	>2.342	<0.715
84	>1.562	<0.333	N/A	N/A	>28.402	< 2.236	N/A	N/A	>2.343	<0.724
85	>1.565	<0.336	N/A	N/A	>28.516	< 2.243	N/A	N/A	>2.344	<0.737
86	>1.568	<0.339	N/A	N/A	>28.620	< 2.262	N/A	N/A	>2.346	<0.747
87	>1.571	<0.343	N/A	N/A	>28.716	< 2.271	N/A	N/A	>2.348	<0.748
88	>1.574	<0.347	N/A	N/A	>28.805	< 2.284	N/A	N/A	>2.350	<0.748
89	>1.577	<0.350	N/A	N/A	>28.881	< 2.299	N/A	N/A	>2.351	<0.748
90	>1.580	<0.356	N/A	N/A	>28.935	< 2.308	N/A	N/A	>2.351	<0.748
91	>1.583	<0.358	N/A	N/A	>28.993	< 2.326	N/A	N/A	>2.351	<0.748
92	>1.586	<0.360	N/A	N/A	>29.044	< 2.330	N/A	N/A	>2.351	<0.748
93	>1.589	<0.363	N/A	N/A	>29.085	< 2.331	N/A	N/A	>2.352	<0.748
94	>1.592	<0.367	>0.017	<0.000	>29.121	< 2.344	> 0.355	< 0.000	>2.353	<0.748
95	>1.594	<0.370	>0.048	<0.000	>29.171	< 2.347	> 0.974	< 0.000	>2.356	<0.748
96	>1.596	<0.372	>0.093	<0.000	>29.241	< 2.355	> 1.646	< 0.000	>2.361	<0.748
97	>1.599	<0.376	>0.159	<0.000	>29.341	< 2.395	> 2.343	< 0.000	>2.368	<0.748

98	>1.602	<0.388	>0.188	<0.000	>29.376	< 2.451	> 2.954	< 0.000	>2.377	<0.748
99	>1.605	<0.396	>0.213	<0.000	>29.382	< 2.508	> 3.475	< 0.004	>2.387	<0.751
100	>1.608	<0.405	>0.234	<0.001	>29.404	< 2.590	> 3.942	< 0.008	>2.398	<0.764
101	>1.611	<0.410	>0.265	<0.002	>29.474	< 2.660	> 4.477	< 0.015	>2.405	<0.789
102	>1.614	<0.411	>0.288	<0.003	>29.565	< 2.749	> 5.050	< 0.026	>2.409	<0.822
103	>1.617	<0.412	>0.308	<0.006	>29.616	< 2.913	> 5.577	< 0.038	>2.411	<0.867
104	>1.620	<0.413	>0.329	<0.007	>29.669	< 3.162	> 6.008	< 0.038	>2.412	<0.905
105	>1.622	<0.421	>0.343	<0.008	>29.735	< 3.170	> 6.180	< 0.039	>2.447	<0.925
106	>1.624	<0.428	>0.350	<0.009	>29.799	< 3.197	> 6.282	< 0.061	>2.516	<0.955
107	>1.626	<0.430	>0.365	<0.010	>29.818	< 3.288	> 6.384	< 0.062	>2.581	<0.985
108	>1.628	<0.455	>0.379	<0.013	>29.826	< 3.419	> 6.451	< 0.108	>2.627	<0.993
109	>1.630	<0.459	>0.389	<0.015	>29.833	< 3.587	> 6.496	< 0.168	>2.650	<0.995
110	>1.632	<0.462	>0.395	<0.017	>29.834	< 3.595	> 6.526	< 0.173	>2.661	<0.996
111	>1.634	<0.464	>0.400	<0.021	>29.836	< 3.640	> 6.561	< 0.237	>2.667	<1.010
112	>1.636	<0.466	>0.403	<0.024	>29.895	< 3.740	> 6.582	< 0.266	>2.677	<1.028
113	>1.638	<0.468	>0.405	<0.024	>29.938	< 3.868	> 6.596	< 0.280	>2.694	<1.034
114	>1.640	<0.471	>0.408	<0.025	>29.947	< 3.877	> 6.608	< 0.291	>2.708	<1.044
115	>1.642	<0.488	>0.410	<0.026	>29.951	< 3.934	> 6.618	< 0.314	>2.716	<1.059
116	>1.644	<0.513	>0.411	<0.029	>29.955	< 4.015	> 6.625	< 0.331	>2.720	<1.075
117	>1.646	<0.538	>0.413	<0.032	>29.977	< 4.061	> 6.629	< 0.345	>2.723	<1.080
118	>1.648	<0.561	>0.414	<0.035	>29.997	< 4.063	> 6.635	< 0.350	>2.725	<1.080
119	>1.650	<0.577	>0.416	<0.035	>30.019	< 4.079	> 6.641	< 0.356	>2.726	<1.081
120	>1.652	<0.580	>0.417	<0.036	>30.024	< 4.140	> 6.654	< 0.367	>2.730	<1.091
121	>1.653	<0.586	>0.418	<0.038	>30.024	< 4.185	> 6.933	< 0.388	>2.740	<1.096
122	>1.655	<0.594	>0.419	<0.040	>30.024	< 4.199	> 7.278	< 0.407	>2.754	<1.111
123	>1.657	<0.603	>0.420	<0.041	>30.024	< 4.205	> 7.660	< 0.463	>2.771	<1.122
124	>1.660	<0.610	>0.420	<0.042	>30.026	< 4.212	> 7.974	< 0.480	>2.791	<1.135
125	>1.666	<0.615	>0.421	<0.042	>30.026	< 4.232	> 8.210	< 0.506	>2.811	<1.138
126	>1.670	<0.624	>0.422	<0.042	>30.026	< 4.298	> 8.382	< 0.518	>2.827	<1.139
127	>1.673	<0.628	>0.422	<0.045	>30.026	< 4.344	> 8.534	< 0.522	>2.837	<1.139
128	>1.676	<0.632	>0.423	<0.046	>30.026	< 4.361	> 8.661	< 0.525	>2.843	<1.139
129	>1.681	<0.637	>0.423	<0.046	>30.027	< 4.366	> 8.754	< 0.528	>2.847	<1.139
130	>1.686	<0.641	>0.424	<0.049	>30.027	< 4.369	> 8.822	< 0.530	>2.850	<1.139
131	>1.692	<0.643	>0.424	<0.050	>30.027	< 4.372	> 8.877	< 0.530	>2.852	<1.139
132	>1.696	<0.644	>0.425	<0.052	>30.055	< 4.435	> 8.927	< 0.534	>2.853	<1.139
133	>1.700	<0.645	>0.425	<0.054	>30.102	< 4.523	> 8.985	< 0.550	>2.854	<1.139
134	>1.703	<0.647	>0.426	<0.054	>30.103	< 4.524	> 9.076	< 0.554	>2.854	<1.139
135	>1.705	<0.651	>0.426	<0.054	>30.104	< 4.525	> 9.206	< 0.590	>2.856	<1.139
136	>1.709	<0.658	>0.426	<0.055	>30.104	< 4.531	> 9.433	< 0.616	>2.870	<1.160
137	>1.716	<0.663	>0.427	<0.055	>30.124	< 4.534	> 9.773	< 0.639	>2.902	<1.174
138	>1.722	<0.666	>0.427	<0.056	>30.417	< 4.542	>10.066	< 0.653	>2.935	<1.183
139	>1.725	<0.668	>0.428	<0.059	>30.642	< 4.553	>10.291	< 0.662	>2.956	<1.197
140	>1.726	<0.670	>0.428	<0.061	>30.882	< 4.554	>10.531	< 0.683	>2.977	<1.223
141	>1.729	<0.672	>0.429	<0.061	>31.082	< 4.554	>10.731	< 0.696	>2.996	<1.255
142	>1.733	<0.675	>0.429	<0.061	>31.199	< 4.554	>10.848	< 0.708	>3.010	<1.272
143	>1.736	<0.678	>0.429	<0.063	>31.264	< 4.554	>11.008	< 0.721	>3.019	<1.286
144	>1.738	<0.681	>0.429	<0.064	>31.306	< 4.554	>11.124	< 0.739	>3.024	<1.304
145	>1.740	<0.684	>0.430	<0.065	>31.336	< 4.554	>11.183	< 0.742	>3.028	<1.307
146	>1.742	<0.686	>0.430	<0.066	>31.352	< 4.554	>11.248	< 0.743	>3.032	<1.312
147	>1.745	<0.688	>0.430	<0.067	>31.370	< 4.554	>11.387	< 0.745	>3.038	<1.317
148	>1.747	<0.690	>0.430	<0.068	>31.399	< 4.554	>11.573	< 0.748	>3.046	<1.321
149	>1.749	<0.692	>0.431	<0.069	>31.423	< 4.554	>11.718	< 0.751	>3.052	<1.325
150	>1.751	<0.694	>0.431	<0.070	>31.435	< 4.554	>11.803	< 0.762	>3.056	<1.328
151	>1.755	<0.696	>0.431	<0.071	>31.444	< 4.556	>11.851	< 0.789	>3.058	<1.332
152	>1.757	<0.698	>0.444	<0.072	>31.473	< 4.556	>11.878	< 0.790	>3.060	<1.338
153	>1.759	<0.700	>0.466	<0.073	>31.536	< 4.565	>12.623	< 0.794	>3.065	<1.344
154	>1.762	<0.702	>0.475	<0.073	>31.599	< 4.612	>13.534	< 0.799	>3.074	<1.350
155	>1.764	<0.704	>0.479	<0.074	>31.637	< 4.834	>14.410	< 0.805	>3.082	<1.357
156	>1.766	<0.706	>0.481	<0.077	>31.655	< 5.702	>14.848	< 0.842	>3.088	<1.365
157	>1.768	<0.708	>0.486	<0.079	>32.005	< 5.841	>14.932	< 0.990	>3.096	<1.379
158	>1.770	<0.710	>0.493	<0.082	>34.442	< 6.170	>14.949	< 1.038	>3.118	<1.414
159	>1.772	<0.712	>0.515	<0.082	>36.064	< 6.670	>14.956	< 1.357	>3.153	<1.466
160	>1.774	<0.716	>0.523	<0.086	>36.390	< 7.425	>14.959	< 1.455	>3.192	<1.514
161	>1.779	<0.750	>0.527	<0.095	>36.445	< 8.379	>14.963	< 1.546	>3.227	<1.559
162	>1.782	<0.784	>0.530	<0.107	>36.458	< 9.648	>14.966	< 1.824	>3.252	<1.591
163	>1.785	<0.805	>0.532	<0.115	>36.508	<10.918	>14.969	< 2.746	>3.270	<1.641
164	>1.790	<0.840	>0.535	<0.122	>36.623	<12.157	>14.976	< 3.073	>3.284	<1.719
165	>1.793	<0.853	>0.537	<0.127	>36.881	<12.731	>14.987	< 3.633	>3.302	<1.777
166	>1.796	<0.874	>0.539	<0.159	>37.220	<12.831	>15.574	< 4.505	>3.331	<1.832
167	>1.801	<0.903	>0.541	<0.186	>37.465	<12.892	>15.779	< 4.952	>3.359	<1.919
168	>1.807	<0.910	>0.542	<0.189	>37.593	<12.932	>15.815	< 5.254	>3.385	<1.972
169	>1.810	<0.914	>0.551	<0.200	>37.663	<13.702	>15.826	< 5.730	>3.412	<2.013
170	>1.812	<0.916	>0.561	<0.220	>37.682	<14.139	>15.834	< 6.051	>3.439	<2.100
171	>1.813	<0.919	>0.578	<0.236	>37.805	<14.964	>15.840	< 6.333	>3.465	<2.200
172	>1.815	<0.931	>0.589	<0.247	>37.878	<15.704	>15.881	< 6.490	>3.482	<2.251

173	>1.817	<0.948	>0.598	<0.257	>37.890	<16.253	>15.901	< 6.796	>3.489	<2.270
174	>1.820	<0.983	>0.608	<0.267	>37.896	<16.907	>15.914	< 7.205	>3.493	<2.301
175	>1.823	<1.018	>0.612	<0.283	>37.901	<17.655	>15.923	< 8.151	>3.496	<2.318
176	>1.825	<1.027	>0.620	<0.295	>37.907	<18.020	>15.930	< 8.230	>3.499	<2.335
177	>1.828	<1.035	>0.623	<0.312	>37.907	<18.349	>15.945	< 8.584	>3.504	<2.349
178	>1.830	<1.051	>0.626	<0.318	>37.907	<18.671	>16.001	< 8.800	>3.512	<2.387
179	>1.833	<1.074	>0.632	<0.323	>37.907	<18.972	>16.042	< 8.847	>3.525	<2.423
180	>1.836	<1.084	>0.635	<0.337	>37.907	<19.228	>16.058	< 8.913	>3.538	<2.462
181	>1.838	<1.099	>0.637	<0.345	>37.908	<20.123	>16.066	< 9.122	>3.547	<2.503
182	>1.839	<1.121	>0.638	<0.350	>37.914	<20.405	>16.071	< 9.532	>3.553	<2.545
183	>1.841	<1.132	>0.639	<0.359	>37.927	<20.754	>16.073	<10.256	>3.559	<2.586
184	>1.849	<1.152	>0.642	<0.387	>37.927	<21.684	>16.076	<10,862	>3.570	<2.627
185	>1.877	<1.161	>0.644	<0.398	>37.927	<21.955	>16.079	<10.996	>3.588	<2.673
186	>1.893	<1.168	>0.646	<0.400	>37.927	<22.650	>16.082	<11.206	>3.596	<2.749
187	>1.907	<1.175	>0.648	<0.402	>37.927	<22.989	>16.083	<11.514	>3.601	<2.804
188	>1.919	<1.181	>0.650	<0.405	>37.927	<23.535	>16.084	<11.894	>3.606	<2.851
189	>1.930	<1.188	>0.652	<0.418	>37.927	<23.876	>16.085	<12.019	>3.617	<2.894
190	>1.937	<1.203	>0.653	<0.429	>37.927	<24.018	>16.091	<12.170	>3.631	<2.931
191	>1.942	<1.219	>0.655	<0.442	>37.927	<24.464	>16.255	<12.517	>3.639	<2.971
192	>1.947	<1.233	>0.656	<0.457	>37.927	<24.685	>16.305	<12.598	>3.644	<3.020
193	>1.951	<1.251	>0.657	<0.473	>37.927	<24.931	>16.347	<12.625	>3.657	<3.077
194	>1.955	<1.255	>0.659	<0.487	>37.927	<25.188	>16.357	<12.653	>3.673	<3.132
195	>1.958	<1.258	>0.660	<0.501	>37.927	<25.468	>16.379	<12.777	>3.687	<3.185
196	>1.962	<1.265	>0.661	<0.510	>37.927	<25.627	>16.397	<12.906	>3.704	<3.219
197	>1.965	<1.280	>0.662	<0.512	>37.927	<25.746	>16.406	<12.989	>3.721	<3.268
198	>1.968	<1.293	>0.663	<0.514	>37.927	<25.850	>16.413	<13.060	>3.731	<3.299
199	>1.971	<1.301	>0.664	<0.516	>37.927	<25.974	>16.444	<13.165	>3.739	<3.350
200	>1.974	<1.313	>0.665	<0.518	>37.927	<26.141	>16.444	<13.242	>3.751	<3.406
201	>1.977	<1.324	>0.666	<0.527	>37.927	<26.225	>16.449	<13.412	>3.764	<3.466
202	>1.979	<1.332	>0.667	<0.540	>37.927	<26.338	>16.464	<13.662	>3.775	<3.497
203	>1.984	<1.341	>0.668	<0.547	>37.933	<26.547	>16.464	<13.773	>3.780	<3.514
204	>1.991	<1.357	>0.672	<0.553	>37.940	<26.818	>16.464	<13.942	>3.782	<3.517
205	>1.996	<1.375	>0.676	<0.559	>37.940	<27.052	>16.474	<14.090	>3.783	<3.519
206	>1.999	<1.392	>0.678	<0.563	>37.940	<27.393	>16.477	<14.224	>3.785	<3.523
207	>2.001	<1.408	>0.679	<0.567	>37.940	<27.501	>16.487	<14.426	>3.792	<3.545
208	>2.002	<1.422	>0.680	<0.571	>37.940	<27.632	>16.558	<14.498	>3.808	<3.570
209	>2.004	<1.433	>0.683	<0.575	>37.940	<27.803	>16.611	<14.776	>3.820	<3.600
210	>2.006	<1.443	>0.689	<0.579	>37.940	<27.953	>16.632	<14.907	>3.834	<3.619
211	>2.008	<1.453	>0.691	<0.595	>37.940	<28.205	>16.634	<14.916	>3.858	<3.639
212	>2.010	<1.463	>0.692	<0.605	>37.940	<28.543	>16.634	<15.014	>3.879	<3.686
213	>2.012	<1.468	>0.693	<0.614	>37.940	<28.997	>16.636	<15.221	>3.893	<3.732
214	>2.015	<1.470	>0.694	<0.622	>37.940	<29.000	>16.648	<15.472	>3.918	<3.791
215	>2.017	<1.474	>0.695	<0.627	>37.940	<29.005	>16.650	<15.555	>3.944	<3.833
216	>2.020	<1.478	>0.696	<0.638	>37.940	<29.081	>16.650	<15.652	>3.970	<3.890
217	>2.021	<1.481	>0.696	<0.643	>37.940	<29.281	>16.732	<15.969	>3.990	<3.932
218	>2.023	<1.484	>0.697	<0.643	>37.975	<29.483	>16.813	<16.028	>4.004	<3.960
219	>2.028	<1.487	>0.698	<0.645	>38.120	<29.734	>16.829	<16.375	>4.013	<3.997
220	>2.033	<1.490	>0.698	<0.651	>38.204	<29,803	>16.845	<16.487	>4.018	<4.013
221	>2.037	<1.493	>0.699	<0.655	>38.207	<29.821	>16.861	<16.524	>4.020	<4.035
222	>2.039	<1.504	>0.699	<0.663	>38.207	<29.847	>16.878	<16,578	>4.024	<4.038
223	>2.041	<1.522	>0.700	<0.671	>38.207	<29.862	>16.888	<16.684	>4.031	<4.050
224	>2,042	<1,547	>0.701	<0.675	>38.207	<29.873	>16.892	<16.755	>4.035	<4.066
225	>2.044	<1.549	>0.701	<0.684	>38.207	<30.008	>16.892	<16.770	>4.037	<4.070
226	>2.045	<1.562	>0.701	<0.694	>38.207	<30.126	>16.893	<16.805	>4.038	<4.072
227	>2.056	<1.574	>0.702	<0.701	>38.207	<30.127	>16.894	<16.865	>4.039	<4.072
228	>2.067	<1.579	>0.704	<0.702	>38.207	<30.127	>16.894	<16.960	>4.040	<4.073
229	>2.071	<1.584	>0.706	<0.708	>38.207	<30.208	>16.894	<16.960	>4.042	<4.073
230	>2.074	<1.589	>0.707	<0.708	>38.207	<30.314	>16.894	<16.962	>4.043	<4.073
231	>2.076	<1.590	>0.708	<0.709	>38.207	<30.323	>16.895	<16.988	>4.044	<4.073
232	>2.081	<1.596	>0.709	<0.710	>38.207	<30.325	>16.895	<17.072	>4.045	<4.074
233	>2.086	<1.598	>0.710	<0.710	>38.207	<30.368	>16.895	<17.094	>4.046	<4.074
234	>2.089	<1.604	>0.710	<0.711	>38.207	<30.411	>16.895	<17.184	>4.046	<4.075
235	>2.091	<1.610	>0.710	<0.712	>38.207	<30.416	>16.896	<17.187	>4.047	<4.075
236	>2.092	<1.612	>0.711	<0.712	>38.207	<30.428	>16.899	<17.188	>4.048	<4.076
237	>2.093	<1.613	>0.711	<0.712	>38.207	<30.430	>16.907	<17.189	>4.050	<4.076
238	>2.095	<1.614	>0.711	<0.713	>38.207	<30.452	>16.920	<17.241	>4.055	<4.076
239	>2.096	<1.615	>0.711	<0.716	>38.207	<30.488	>16.932	<17.370	>4.058	<4.076

Table 2A: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1984-1987

(Reserved)

Table 2B: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1988-1990

(Reserved)

Table 2C: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1991-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

(Reserved)

Table 2D: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight less than or equal to 3,750 pounds

(Reserved)

Table 2E: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight greater than 3,750 pounds

(Reserved)

Table 3A: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1984-1987

(Reserved)

Table 3B: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1988-1990

(Reserved)

Table 3C: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1991-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

(Reserved)

Table 3D: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight less than or equal to 5,750 pounds

(Reserved)

Table 3E: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used from January 1, 1995 through December 31, 1997
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight greater than 5,750 pounds

(Reserved)

Table 4A: Light-Duty Gasoline Vehicles
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1983-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

SECS IM240	HC Fail Composite	HC Pass Composite	HC Fail Phase 2	HC Pass Phase 2	CO Fail Composite	CO Pass Composite	CO Fail Phase 2	CO Pass Phase 2	NO Fail	NO Pass
30	>1.193	<0.124	N/A	N/A	>16.540	< 0.693	N/A	N/A	>1.422	<0.167
31	>1.207	<0.126	N/A	N/A	>17.419	< 0.773	N/A	N/A	>1.453	<0.177
32	>1.221	<0.129	N/A	N/A	>18.132	< 0.837	N/A	N/A	>1.510	<0.188
33	>1.234	<0.135	N/A	N/A	>18.601	< 0.851	N/A	N/A	>1.585	<0.214
34	>1.246	<0.140	N/A	N/A	>18.846	< 0.853	N/A	N/A	>1.658	<0.232
35	>1.258	<0.146	N/A	N/A	>18.993	< 0.857	N/A	N/A	>1.717	<0.240
36	>1.270	<0.150	N/A	N/A	>19.083	< 0.900	N/A	N/A	>1.760	<0.243
37	>1.281	<0.153	N/A	N/A	>19.136	< 0.960	N/A	N/A	>1.792	<0.245
38	>1.292	<0.156	N/A	N/A	>19.169	< 1.034	N/A	N/A	>1.817	<0.246
39	>1.303	<0.160	N/A	N/A	>19.196	< 1.070	N/A	N/A	>1.836	<0.246
40	>1.313	<0.165	N/A	N/A	>19.227	< 1.076	N/A	N/A	>1.852	<0.250
41	>1.323	<0.169	N/A	N/A	>19.288	< 1.083	N/A	N/A	>1.866	<0.260
42	>1.332	<0.172	N/A	N/A	>19.376	< 1.102	N/A	N/A	>1.875	<0.277
43	>1.341	<0.173	N/A	N/A	>19.465	< 1.111	N/A	N/A	>1.883	<0.311
44	>1.350	<0.177	N/A	N/A	>19.522	< 1.114	N/A	N/A	>1.909	<0.328
45	>1.359	<0.197	N/A	N/A	>19.590	< 1.157	N/A	N/A	>1.960	<0.343
46	>1.367	<0.200	N/A	N/A	>19.647	< 1.344	N/A	N/A	>2.014	<0.359
47	>1.375	<0.208	N/A	N/A	>19.678	< 1.482	N/A	N/A	>2.056	<0.373
48	>1.383	<0.221	N/A	N/A	>19.695	< 1.530	N/A	N/A	>2.092	<0.383
49	>1.390	<0.232	N/A	N/A	>19.727	< 1.542	N/A	N/A	>2.133	<0.385
50	>1.397	<0.235	N/A	N/A	>20.011	< 1.553	N/A	N/A	>2.178	<0.400
51	>1.404	<0.238	N/A	N/A	>20.510	< 1.571	N/A	N/A	>2.219	<0.410
52	>1.411	<0.240	N/A	N/A	>21.038	< 1.595	N/A	N/A	>2.252	<0.434
53	>1.417	<0.242	N/A	N/A	>21.587	< 1.633	N/A	N/A	>2.275	<0.464
54	>1.423	<0.246	N/A	N/A	>22.148	< 1.685	N/A	N/A	>2.288	<0.472
55	>1.429	<0.249	N/A	N/A	>22.728	< 1.689	N/A	N/A	>2.294	<0.480
56	>1.435	<0.252	N/A	N/A	>23.312	< 1.693	N/A	N/A	>2.296	<0.491
57	>1.441	<0.261	N/A	N/A	>23.869	< 1.700	N/A	N/A	>2.297	<0.500
58	>1.447	<0.271	N/A	N/A	>24.389	< 1.723	N/A	N/A	>2.298	<0.506
59	>1.452	<0.276	N/A	N/A	>24.845	< 1.852	N/A	N/A	>2.299	<0.509

60	>1.457	<0.278	N/A	N/A	>25.217	< 1.872	N/A	N/A	>2.300	<0.512
61	>1.462	<0.280	N/A	N/A	>25.554	< 1.872	N/A	N/A	>2.301	<0.516
62	>1.467	<0.282	N/A	N/A	>25.826	< 1.872	N/A	N/A	>2.304	<0.519
63	>1.472	<0.283	N/A	N/A	>25.973	< 1.900	N/A	N/A	>2.310	<0.523
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65	>1.482	<0.285	N/A	N/A	>26.082	< 1.944	N/A	N/A	>2.320	<0.533
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69	>1.502	<0.294	N/A	N/A	>26.168	< 2.076	N/A	N/A	>2.339	<0.563
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95	>1.594	<0.370	>0.048	<0.000	>29.171	< 2.347	> 0.974	< 0.000	>2.356	<0.748
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109	>1.630	<0.459	>0.389	<0.015	>29.833	< 3.587	> 6.496	< 0.168	>2.650	<0.995
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111	>1.634	<0.464	>0.400	<0.021	>29.836	< 3.640	> 6.561	< 0.237	>2.667	<1.010
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115	>1.642	<0.488	>0.410	<0.026	>29.951	< 3.934	> 6.618	< 0.314	>2.716	<1.059
116	>1.644	<0.513	>0.411	<0.029	>29.955	< 4.015	> 6.625	< 0.331	>2.720	<1.075
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160	>1.774	<0.716	>0.523	<0.086	>36.390	< 7.425	>14.959	< 1.455	>3.192	<1.514
161	>1.779	<0.750	>0.527	<0.095	>36.445	< 8.379	>14.963	< 1.546	>3.227	<1.559
162	>1.782	<0.784	>0.530	<0.107	>36.458	< 9.648	>14.966	< 1.824	>3.252	<1.591
163	>1.785	<0.805	>0.532	<0.115	>36.508	<10.918	>14.969	< 2.746	>3.270	<1.641
164	>1.790	<0.840	>0.535	<0.122	>36.623	<12.157	>14.976	< 3.073	>3.284	<1.719
165	>1.793	<0.853	>0.537	<0.127	>36.881	<12.731	>14.987	< 3.633	>3.302	<1.777
166	>1.796	<0.874	>0.539	<0.159	>37.220	<12.831	>15.574	< 4.505	>3.331	<1.832
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179	>1.833	<1.074	>0.632	<0.323	>37.907	<18.972	>16.042	< 8.847	>3.525	<2.423
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183	>1.841	<1.132	>0.639	<0.359	>37.927	<20.754	>16.073	<10.256	>3.559	<2.586
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191	>1.942	<1.219	>0.655	<0.442	>37.927	<24.464	>16.255	<12.517	>3.639	<2.971
192	>1.947	<1.233	>0.656	<0.457	>37.927	<24.685	>16.305	<12.598	>3.644	<3.020
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195	>1.958	<1.258	>0.660	<0.501	>37.927	<25.468	>16.379	<12.777	>3.687	<3.185
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201	>1.977	<1.324	>0.666	<0.527	>37.927	<26.225	>16.449	<13.412	>3.764	<3.466
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203	>1.984	<1.341	>0.668	<0.547	>37.933	<26.547	>16.464	<13.773	>3.780	<3.514
204	>1.991	<1.357	>0.672	<0.553	>37.940	<26.818	>16.464	<13.942	>3.782	<3.517
205	>1.996	<1.375	>0.676	<0.559	>37.940	<27.052	>16.474	<14.090	>3.783	<3.519
206	>1.999	<1.392	>0.678	<0.563	>37.940	<27.393	>16.477	<14.224	>3.785	<3.523
207	>2.001	<1.408	>0.679	<0.567	>37.940	<27.501	>16.487	<14.426	>3.792	<3.545
208	>2.002	<1.422	>0.680	<0.571	>37.940	<27.632	>16.558	<14.498	>3.808	<3.570
209	>2.004	<1.433	>0.683	<0.575	>37.940	<27.803	>16.611	<14.776	>3.820	<3.600

210	>2.006	<1.443	>0.689	<0.579	>37.940	<27.953	>16.632	<14.907	>3.834	<3.619
211	>2.008	<1.453	>0.691	<0.595	>37.940	<28.205	>16.634	<14.916	>3.858	<3.639
212	>2.010	<1.463	>0.692	<0.605	>37.940	<28.543	>16.634	<15.014	>3.879	<3.686
213	>2.012	<1.468	>0.693	<0.614	>37.940	<28.997	>16.636	<15.221	>3.893	<3.732
214	>2.015	<1.470	>0.694	<0.622	>37.940	<29.000	>16.648	<15.472	>3.918	<3.791
215	>2.017	<1.474	>0.695	<0.627	>37.940	<29.005	>16.650	<15.555	>3.944	<3.833
216	>2.020	<1.478	>0.696	<0.638	>37.940	<29.081	>16.650	<15.652	>3.970	<3.890
217	>2.021	<1.481	>0.696	<0.643	>37.940	<29.281	>16.732	<15.969	>3.990	<3.932
218	>2.023	<1.484	>0.697	<0.643	>37.975	<29.483	>16.813	<16.028	>4.004	<3.960
219	>2.028	<1.487	>0.698	<0.645	>38.120	<29.734	>16.829	<16.375	>4.013	<3.997
220	>2.033	<1.490	>0.698	<0.651	>38.204	<29.803	>16.845	<16.487	>4.018	<4.013
221	>2.037	<1.493	>0.699	<0.655	>38.207	<29.821	>16.861	<16.524	>4.020	<4.035
222	>2.039	<1.504	>0.699	<0.663	>38.207	<29.847	>16.878	<16.578	>4.024	<4.038
223	>2.041	<1.522	>0.700	<0.671	>38.207	<29.862	>16.888	<16.684	>4.031	<4.050
224	>2.042	<1.547	>0.701	<0.675	>38.207	<29.873	>16.892	<16.755	>4.035	<4.066
225	>2.044	<1.549	>0.701	<0.684	>38.207	<30.008	>16.892	<16.770	>4.037	<4.070
226	>2.045	<1.562	>0.701	<0.694	>38.207	<30.126	>16.893	<16.805	>4.038	<4.072
227	>2.056	<1.574	>0.702	<0.701	>38.207	<30.127	>16.894	<16.865	>4.039	<4.072
228	>2.067	<1.579	>0.704	<0.702	>38.207	<30.127	>16.894	<16.960	>4.040	<4.073
229	>2.071	<1.584	>0.706	<0.708	>38.207	<30.208	>16.894	<16.960	>4.042	<4.073
230	>2.074	<1.589	>0.707	<0.708	>38.207	<30.314	>16.894	<16.962	>4.043	<4.073
231	>2.076	<1.590	>0.708	<0.709	>38.207	<30.323	>16.895	<16.988	>4.044	<4.073
232	>2.081	<1.596	>0.709	<0.710	>38.207	<30.325	>16.895	<17.072	>4.045	<4.074
233	>2.086	<1.598	>0.710	<0.710	>38.207	<30.368	>16.895	<17.094	>4.046	<4.074
234	>2.089	<1.604	>0.710	<0.711	>38.207	<30.411	>16.895	<17.184	>4.046	<4.075
235	>2.091	<1.610	>0.710	<0.712	>38.207	<30.416	>16.896	<17.187	>4.047	<4.075
236	>2.092	<1.612	>0.711	<0.712	>38.207	<30.428	>16.899	<17.188	>4.048	<4.076
237	>2.093	<1.613	>0.711	<0.712	>38.207	<30.430	>16.907	<17.189	>4.050	<4.076
238	>2.095	<1.614	>0.711	<0.713	>38.207	<30.452	>16.920	<17.241	>4.055	<4.076
239	>2.096	<1.615	>0.711	<0.716	>38.207	<30.488	>16.932	<17.370	>4.058	<4.076

Table 4B: Light-Duty Gasoline Vehicles
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles

(Reserved)

Table 5A: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1984-1987

(Reserved)

Table 5B: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1988-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

(Reserved)

Table 5C: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight less than or equal to 3,750 pounds

(Reserved)

Table 5D: Light-Duty Gasoline Truck 1
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight greater than 3,750 pounds

(Reserved)

Table 6A: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1984-1987

(Reserved)

Table 6B: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1988-1995, not including 1994 and 1995 vehicles certified to Tier 1 standards

(Reserved)

Table 6C: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight less than or equal to 5,750 pounds

(Reserved)

Table 6D: Light-Duty Gasoline Truck 2
IM240 Fast-Pass/Fast-Fail Standards
To be used on and after January 1, 1998
Model Years 1994-1995 certified to Tier 1 standards and all 1996 and newer vehicles with a loaded vehicle weight greater than 5,750 pounds

(Reserved)

Table 7: Purge Fast-Pass/Fast-Fail Standards

SECS IM240	Purge Fail	Purge Pass	45	N/A	>0.20
			46	N/A	>0.21
30	N/A	>0.14	47	N/A	>0.22
31	N/A	>0.14	48	N/A	>0.22
32	N/A	>0.15	49	N/A	>0.22
33	N/A	>0.15	50	N/A	>0.23
34	N/A	>0.16	51	N/A	>0.24
35	N/A	>0.16	52	N/A	>0.24
36	N/A	>0.16	53	N/A	>0.24
37	N/A	>0.17	54	N/A	>0.24
38	N/A	>0.18	55	N/A	>0.24
39	N/A	>0.18	56	N/A	>0.24
40	N/A	>0.19	57	N/A	>0.24
41	N/A	>0.19	58	N/A	>0.25
42	N/A	>0.19	59	N/A	>0.25
43	N/A	>0.20	60	N/A	>0.25
44	N/A	>0.20	61	N/A	>0.26

62	N/A	>0.26	138	N/A	>0.54	214	N/A	>0.85	227	N/A	>0.91
63	N/A	>0.26	139	N/A	>0.55	215	N/A	>0.85	228	N/A	>0.92
64	N/A	>0.27	140	N/A	>0.55	216	N/A	>0.86	229	N/A	>0.92
65	N/A	>0.27	141	N/A	>0.56	217	N/A	>0.86	230	N/A	>0.92
66	N/A	>0.27	142	N/A	>0.56	218	N/A	>0.87	231	N/A	>0.92
67	N/A	>0.28	143	N/A	>0.56	219	N/A	>0.87	232	N/A	>0.93
68	N/A	>0.28	144	N/A	>0.56	220	N/A	>0.88	233	N/A	>0.93
69	N/A	>0.29	145	N/A	>0.57	221	N/A	>0.88	234	N/A	>0.93
70	N/A	>0.29	146	N/A	>0.57	222	N/A	>0.88	235	N/A	>0.93
71	N/A	>0.29	147	N/A	>0.58	223	N/A	>0.89	236	N/A	>0.94
72	N/A	>0.29	148	N/A	>0.58	224	N/A	>0.90	237	N/A	>0.94
73	N/A	>0.30	149	N/A	>0.59	225	N/A	>0.90	238	N/A	>0.94
74	N/A	>0.30	150	N/A	>0.59	226	N/A	>0.91	239	N/A	>0.94
75	N/A	>0.30	151	N/A	>0.59						
76	N/A	>0.31	152	N/A	>0.59						
77	N/A	>0.31	153	N/A	>0.59						
78	N/A	>0.32	154	N/A	>0.59						
79	N/A	>0.32	155	N/A	>0.60						
80	N/A	>0.32	156	N/A	>0.60						
81	N/A	>0.32	157	N/A	>0.61						
82	N/A	>0.33	158	N/A	>0.61						
83	N/A	>0.33	159	N/A	>0.61						
84	N/A	>0.34	160	N/A	>0.61						
85	N/A	>0.34	161	N/A	>0.62						
86	N/A	>0.34	162	N/A	>0.62						
87	N/A	>0.35	163	N/A	>0.63						
88	N/A	>0.35	164	N/A	>0.63						
89	N/A	>0.35	165	N/A	>0.64						
90	N/A	>0.36	166	N/A	>0.64						
91	N/A	>0.36	167	N/A	>0.64						
92	N/A	>0.37	168	N/A	>0.65						
93	N/A	>0.37	169	N/A	>0.65						
94	N/A	>0.37	170	N/A	>0.66						
95	N/A	>0.38	171	N/A	>0.66						
96	N/A	>0.38	172	N/A	>0.67						
97	N/A	>0.39	173	N/A	>0.67						
98	N/A	>0.39	174	N/A	>0.68						
99	N/A	>0.39	175	N/A	>0.68						
100	N/A	>0.40	176	N/A	>0.68						
101	N/A	>0.40	177	N/A	>0.68						
102	N/A	>0.40	178	N/A	>0.68						
103	N/A	>0.41	179	N/A	>0.68						
104	N/A	>0.41	180	N/A	>0.68						
105	N/A	>0.41	181	N/A	>0.68						
106	N/A	>0.42	182	N/A	>0.68						
107	N/A	>0.42	183	N/A	>0.68						
108	N/A	>0.43	184	N/A	>0.68						
109	N/A	>0.43	185	N/A	>0.68						
110	N/A	>0.43	186	N/A	>0.69						
111	N/A	>0.44	187	N/A	>0.70						
112	N/A	>0.44	188	N/A	>0.72						
113	N/A	>0.44	189	N/A	>0.72						
114	N/A	>0.44	190	N/A	>0.73						
115	N/A	>0.45	191	N/A	>0.73						
116	N/A	>0.46	192	N/A	>0.74						
117	N/A	>0.46	193	N/A	>0.74						
118	N/A	>0.47	194	N/A	>0.74						
119	N/A	>0.47	195	N/A	>0.75						
120	N/A	>0.47	196	N/A	>0.76						
121	N/A	>0.48	197	N/A	>0.76						
122	N/A	>0.48	198	N/A	>0.76						
123	N/A	>0.48	199	N/A	>0.76						
124	N/A	>0.49	200	N/A	>0.77						
125	N/A	>0.49	201	N/A	>0.77						
126	N/A	>0.50	202	N/A	>0.77						
127	N/A	>0.50	203	N/A	>0.78						
128	N/A	>0.50	204	N/A	>0.79						
129	N/A	>0.50	205	N/A	>0.79						
130	N/A	>0.51	206	N/A	>0.80						
131	N/A	>0.52	207	N/A	>0.81						
132	N/A	>0.52	208	N/A	>0.81						
133	N/A	>0.52	209	N/A	>0.82						
134	N/A	>0.53	210	N/A	>0.83						
135	N/A	>0.53	211	N/A	>0.83						
136	N/A	>0.54	212	N/A	>0.84						
137	N/A	>0.54	213	N/A	>0.85						

(a)

POLICY AND PLANNING/AIR QUALITY MANAGEMENT

Control and Prohibition of Air Pollution from Oxides of Nitrogen

Proposed Amendments: N.J.A.C. 7:27-19.1 through 19.10, 19.13, 19.14, 19.15 and 19.19; 7:27A-3.10
Proposed New Rules: N.J.A.C. 7:27-19.20 through 19:25

Authorized By: Robert C. Shinn, Jr., Commissioner, Department of Environmental Protection.

Authority: N.J.S.A. 13:1B-3, 13:1D-9, and 26:2C-1 et seq., in particular 26:2C-9(c) and 19.

DEP Docket Number: 35-94-07/413.

Proposal Number: PRN 1994-466.

A **public hearing** regarding the proposed amendments will be held on Friday, September 16, 1994 at 1:30 P.M., at:

Department of Environmental Protection
Public Hearing Room
401 East State Street, First Floor
Trenton, New Jersey

Submit written comments by September 23, 1994 to:

Janis E. Hoagland, Esq.
Attention: DEP Docket No. 35-94-07/413
Office of Legal Affairs
Department of Environmental Protection
CN 402
Trenton, New Jersey 08625-0402

The proposed amendments will become operative 60 days after adoption (see N.J.S.A. 26:2C-8).

The agency proposal follows:

Summary

On December 20, 1993, the Department of Environmental Protection (Department) promulgated new rules at N.J.A.C. 7:27-19 governing the control and prohibition of air pollution from oxides of nitrogen (NO_x). R.1993 d.682, 25 N.J.R. 5957(a). The Department promulgated those rules in response to the requirements of the Federal Clean Air Act, 42 U.S.C. §7401 et seq. (Act), as amended by the Clean Air Act Amendments of 1990, P.L. 101-549, November 15, 1990 (CAAA).

Under the Act, the United States Environmental Protection Agency (EPA) has established a National Ambient Air Quality Standard (NAAQS) for ozone. 42 U.S.C. §7409(a)(1). The Act requires any state in which the ambient air quality fails to achieve the NAAQS to submit a State Implementation Plan (SIP) to EPA. 42 U.S.C. §7410. The SIP provides for the state to establish enforceable emission limits and other control measures that would enable the state to achieve the NAAQS.

New Jersey is subject to this requirement because it has not attained the NAAQS for ozone. EPA has designated 18 of the State's 21 counties as being in "severe" nonattainment for ozone, based upon ozone levels more than 50 percent above the NAAQS in those areas.

The CAAA further directs states in which severe nonattainment areas are located to revise their SIPs to require major stationary sources of NO_x to implement reasonably available control technology (RACT) to

reduce emissions. P.L. 101-549, §182(f). The CAAA requires this implementation as expeditiously as practicable, but no later than May 31, 1995. See §§182(b)(2), (d) and (f)(1).

When the Department proposed N.J.A.C. 7:27-19 (subchapter 19) to satisfy this requirement, members of the public and the regulated community submitted comments and suggestions. In addition, EPA has provided guidance relevant to the rules. In reviewing the public's comments and EPA's guidance on those rules, the Department determined that substantial revisions were necessary. These proposed amendments make those revisions.

Before proposing these amendments and new rules, the Department has informally sought comments and suggestions from interested persons. The Department contacted the members of the working group that had assisted in the development of the existing rules. This working group consisted of persons who had attended a meeting to which the public was invited, and at that meeting volunteered to participate in the development of the existing rules.

In addition to contacting the members of the original working group, the Department also invited members of the environmental community, and representatives of EPA to participate in the development of the proposed amendments and new rules. However, those persons did not participate. As a result, the informal discussions of the proposed amendments and new rules primarily involved members of the affected regulated communities and environmental consultants. These persons reviewed a rough draft of the proposed amendments and new rules, discussed the draft with Department staff, and submitted written comments.

The specific revisions to subchapter 19 are discussed in detail below:

Seasonal Fuel Switching

Introduction. The existing rule at N.J.A.C. 7:27-19.4 recognizes that NO_x emissions from certain types of coal-fired utility boilers might not practicably be controlled using the types of control techniques available for other utility boilers. The existing rules address that problem by allowing these utility boilers to comply with the rule by seasonally combusting natural gas instead of coal. The boiler would combust natural gas during the "ozone season" from May 1 through September 30 of each year, when ozone levels in the State are most likely to be elevated.

After the existing rules were proposed, several commenters questioned why compliance through seasonal combustion of natural gas was available only for certain utility boilers. The commenters suggested that this means of compliance should be available for all of the combustion sources regulated under subchapter 19.

EPA has supported the commenters' position in part. EPA has advised the Department that the NO_x rules can allow a combustion source that has primarily burned one fuel (coal, for example) to attain compliance by burning a cleaner fuel such as natural gas during the ozone season. However, EPA has stated that a combustion source is not eligible for this method of compliance if it has historically combusted natural gas as its primary fuel.

Based on EPA's guidance, the Department sees no reason to limit seasonal combustion of natural gas to coal-fired wet-bottom utility boilers. Also based on EPA's guidance, the Department sees no reason to restrict this alternative to sources that seasonally combust natural gas; the Department believes that a source should be eligible for this method of compliance if it seasonally combusts any fuel that yields reduced NO_x emissions compared to the primary fuel. For example, a source that uses coal as its primary fuel can reduce its NO_x emissions during the ozone season by combusting fuel oil instead.

Accordingly, the proposed new rule at N.J.A.C. 7:27-19.20 allows all combustion sources subject to subchapter 19 to attain compliance through seasonal combustion of natural gas or any other fuel that is cleaner than the base year fuel. However, the Department expects that the owners and operators of most sources will use natural gas as the cleaner fuel, because natural gas tends to be plentiful and less expensive during the summer ozone season.

This approach provides greater flexibility to owners and operators seeking to comply with subchapter 19, by establishing an alternative approach to compliance that is also effective in protecting air quality. The alternative is feasible because during the ozone season, the price of natural gas in New Jersey historically has been close to the price of other fuels; in addition, compliance through this alternative may enable owners and operators of the boilers to avoid much of the initial capital costs and operating costs associated with installing low-NO_x burners and making other modifications to the combustion process. Furthermore, under seasonal combustion of cleaner fuels larger reductions in NO_x emissions occur during the ozone season, when it is most needed to prevent exceedances of the ozone NAAQS.

Allowing compliance through seasonal combustion of cleaner fuels also removes a disincentive to the use of cleaner fuels. Without this alternative, a source that seasonally combusts a cleaner fuel will be subject to lower NO_x emission limits for that cleaner fuel; the owner or operator of the source normally will not be able to comply with those limits without making capital improvements to the source in addition to paying the usually higher cost of natural gas. The cost of those improvements, and the possibly increased cost of operating and maintaining the source, create a disincentive to using the cleaner fuel at all.

The Department notes that fuel switching may be used in conjunction with averaging. Under a fuel switching plan, a combustion source will be required to meet specified NO_x emission limits each day during the ozone season, and over the entire year. Under an averaging plan, that combustion source could be assigned a more stringent emission limit (which would then allow another unit in the averaging plan to emit more NO_x), or a less stringent limit (which would have to be made up by another unit in the averaging plan which would emit less NO_x). The proposed amendments to N.J.A.C. 7:27-19.6 clarify that fuel switching may be used in conjunction with averaging in this manner.

The Department also notes that a combustion source using fuel switching can employ other control measures to help meet the daily, 30-day and annual NO_x emission limits. It is not necessary to use fuel switching exclusively to meet these limits.

Eligibility. To be eligible for compliance through fuel switching, a combustion source must derive a higher percentage of its total heat input from cleaner fuel than it did during its base year. N.J.A.C. 7:27-19.20(b). This eligibility requirement is based on EPA's guidance. EPA has stated that calendar year 1990 is an appropriate base year because many requirements of the CAAA (such as reasonable further progress and emissions inventories) stem from this date.

N.J.A.C. 7:27-19.1 defines the terms relevant to the eligibility requirement. The "base year" is calendar year 1990, unless the owner or operator of the source demonstrates that calendar year 1991, 1992 or 1993 is more representative of the source's historic operating conditions. The "primary fuel" is the fuel that provided the greatest heat input (in BTU) to the combustion source during a calendar year. A given fuel is a "cleaner fuel" if, all other circumstances being equal, the rate of NO_x emissions from the source (in lb/MMBTU) using the given fuel is less than the rate of NO_x emissions when the primary fuel is combusted. For example, if the source's primary fuel is fuel oil, natural gas would be a "cleaner fuel."

Application requirements. The owner or operator of the combustion source seeking to attain compliance through seasonal fuel switching must submit an application to the Department within 30 days after the operative date of the proposed new rules. N.J.A.C. 7:27-19.20(c). The existing provision at N.J.A.C. 7:27-19.4(b)1, which required the owner or operator of a utility boiler to submit this application by July 1, 1994, is proposed for deletion; as a result, the owner or operator of a utility boiler will gain additional time to submit the application. The existing rules at N.J.A.C. 7:27-19.14 establish the general procedure for the application and the time frames for Department review.

The heart of the application is a calculation of the maximum rate of NO_x emissions that the combustion source must meet over various averaging times. That maximum rate will limit the NO_x emissions from the source averaged over the calendar year, and the NO_x emissions averaged over each calendar day during the ozone season.

The limit on the rate of NO_x emissions is a weighted average of the emissions limits for each fuel that the source combusted during the base year. The weighting is based on the heat input that the source derived from each fuel during the base year.

The limit on the average rate of NO_x emissions is calculated as follows:

1. For each fuel that the source combusted during the base year, determine the heat input (in millions of BTU, abbreviated as MMBTU) that the source derived from the combustion of that fuel. The proposed new rules use the abbreviation "HI_x" to refer to the heat input for each fuel;
2. Determine the maximum allowable emissions rate (in pounds per million BTUs, abbreviated as lb/MMBTU) that the existing rules impose for combustion of each of the fuels listed in paragraph 1 above. The proposed new rules use the abbreviation "L_x" to refer to the maximum allowable emissions rate for each fuel;
3. For each fuel, multiply HI by L;
4. Add all of the amounts determined under paragraph 3 above; and

5. Divide the total determined under 4 above by the sum of all of the heat inputs that the source derived from the combustion of each fuel. The result is the limit on the average rate of NO_x emissions, expressed in pounds per million BTU. However, that limit cannot be greater than the rate that would have applied if the combustion source were combusting the primary fuel that it had used in the base year. Without this exception, a combustion source could conceivably be subject to NO_x emission limits during the ozone season that were less stringent than the NO_x emission limits outside the ozone season (See **Operational requirements—30-day emissions limit outside ozone season** below). That result would contradict the purpose of subchapter 19.

The following example illustrates the calculation of the limit on the average rate of NO_x emissions. The example is for a face-fired dry-bottom utility boiler. In the base year, the boiler derived heat input of 100,000 MMBTU from the combustion of coal, and 50,000 MMBTU from the combustion of fuel oil.

1. Determine the heat input that the source derived from the combustion of each fuel (HI_x). HI_1, for coal, is 100,000 million BTU. HI_2, for fuel oil, is 50,000 million BTU.

2. Determine the maximum allowable emissions rate that the existing rules impose for combustion of each fuel (L_x). Under the existing rules at N.J.A.C. 7:27-19.4, L_1, for coal, is 0.45 lb/MMBTU. L_2, for fuel oil, is 0.28 lb/MMBTU.

3. For each fuel, multiply HI by L.

$HI_1 \times L_1$ = 100,000 MMBTU × 0.45 lb/MMBTU = 45,000 lbs.

$HI_2 \times L_2$ = 50,000 MMBTU × 0.28 lb/MMBTU = 14,000 lbs.

4. Add all of the amounts determined under paragraph 3 above.

45,000 lbs. + 14,000 lbs. = 59,000 lbs.

5. Divide the total determined under paragraph 4 above by the sum of all of the heat inputs that the source derived from the combustion of each fuel.

59,000 lbs. ÷ (100,000 MMBTU + 50,000 MMBTU) = 0.39 lb/MMBTU

The limit on the average rate of NO_x emissions is 0.39 lb/MMBTU.

The one exception to this approach is the emissions limit for coal-fired, wet-bottom utility boilers using the tangential or face firing method. The existing rules at N.J.A.C. 7:27-19.4(b)5 establish an annual NO_x emissions limit of 1.5 lb/MMBTU for such boilers, and the proposed new rules preserve that limit. As discussed in the Summary when the existing rules were first proposed (25 N.J.R. 631(a), February 16, 1993), the Department has determined that this emissions limit represents RACT for this type of boiler.

Emissions cap vs. emissions averaging. In its guidance, EPA has advised the states that compliance through seasonal fuel switching can be demonstrated by using either an emissions cap or emissions averaging. An emissions cap limits the quantity of NO_x that a source can emit during the year. An emissions averaging approach limits the average rate at which the source can emit NO_x during the year. As explained above, the Department has used the emissions averaging approach in the proposed new rules.

The difference between the cap approach and the averaging approach is most apparent when the actual operations of a source differ from its historical operations. If the annual heat input to the source is less than it was in the base year, under an averaging approach the quantity of emissions from the source must be reduced as well; under a cap approach, the limit on NO_x emissions is unchanged. Conversely, if the annual heat input to the source is greater than it was in the base year, an averaging approach would allow the quantity of NO_x emissions to increase; a cap approach would not allow such an increase, so the source would have to reduce the rate at which it emits NO_x in order to maintain compliance.

Participants in the work group formed to discuss the proposed new rules preferred the averaging approach. Those participants felt that the averaging approach was more flexible and reasonable. The Department agrees, and has therefore included that approach in the proposed new rules.

Operational requirements—in general. The proposed new provision at N.J.A.C. 7:27-19.20(g) establishes requirements for the operation of a source that seasonally combusts a cleaner fuel. The owner or operator of the source must comply with these requirements beginning in calendar year 1995.

Operational requirements—daily emissions limit during ozone season. The source must combust a cleaner fuel during the "ozone season," from May 1 through September 15 of each year. N.J.A.C. 7:27-19.20(g)2. Each day during that season, the average rate of NO_x emissions from the source cannot exceed the maximum allowable emission rate calculated under N.J.A.C. 7:27-19.20(d), discussed above.

Under the existing rules, the ozone season runs from May 1 through September 30 of each year. As noted above, under the proposed new rules the ozone season will end on September 15. This revision will make subchapter 19 consistent with the corresponding regulations now in effect in New York. The Department expects the revision to result in a cost savings for sources that seasonally combust natural gas. The savings should result primarily from the difference in price between natural gas and other fuels such as coal.

The Department does not expect that the change in the ozone season will increase the number of exceedances of the NAAQS in New Jersey. Exceedances after September 15 have been rare; none has occurred since September 16, 1991, and the last one before that date occurred in 1986.

Operational requirements—30-day emissions limit outside ozone season. Outside the ozone season, the source must comply with the NO_x emission limit that would have been applicable if the source had been using its historic primary fuel. Compliance with this limit is determined based on the 30-day period that ends on September 16, and each 30-day period that ends on each subsequent day until the following April 30.

For example, if the source is face-fired dry-bottom utility boiler, and its primary fuel in the base year had been coal, the boiler can emit NO_x at an average rate no higher than 0.45 lb/MMBTU during each of the 30-day periods noted above. This rate is the maximum established under N.J.A.C. 7:27-19.7(c) in the existing rules.

The Department had considered not having a 30-day limit for the non-ozone season, but has proposed to include this limit to be consistent with other provisions of the rule and to allow averaging to be used with fuel switching. The Department seeks comments regarding the use of the RACT limit for the primary fuel as the 30-day limit for the non-ozone season. For example, an alternative approach would be to derive the 30-day limit on a source-specific basis, in a manner consistent with the annual limit and daily ozone season limit.

Operational requirements—annual emissions limit. In addition to the daily average applicable during the ozone season, the source must also comply with an annual emissions limit. That limit is calculated by multiplying the limit on the average annual rate of NO_x emissions, as set forth in the application for approval of the averaging plan, by the total heat input to the source during the year. N.J.A.C. 7:27-19.20(j).

The following example illustrates the calculation of the annual limit on the annual quantity of NO_x emissions. The example is the same boiler used above to illustrate how the limit on the average annual rate of NO_x emissions is calculated. In 1998, the boiler derives heat input of 75,000 MMBTU from the combustion of coal, 25,000 MMBTU from the combustion of fuel oil, and 50,000 MMBTU from the combustion of natural gas.

1. As calculated in the example above, the limit on the average annual rate of NO_x emissions is 0.39 lb/MMBTU.

2. To determine the total annual heat input to the boiler, add the heat input derived from each fuel:

75,000 MMBTU (coal) + 25,000 MMBTU (fuel oil) + 100,000 MMBTU (natural gas) = 200,000 MMBTU

3. To determine the limit on the quantity of NO_x emissions from the boiler, multiply the number in paragraph 1 above by the number in paragraph 2 above:

200,000 MMBTU × 0.39 lb/MMBTU = 78,000 lbs.

The boiler can emit no more than 78,000 pounds of NO_x during 1998.

To determine whether the boiler actually complies with this limit in 1998, the owner or operator must determine the average rate at which the boiler emitted NO_x while combusting each of the fuels. The average emissions rate must be based upon continuous emissions monitoring (in accordance with N.J.A.C. 7:27-19.18 in the existing rules) or source emissions testing (in accordance with N.J.A.C. 7:27-19.17 in the existing rules).

The following example illustrates how to determine whether the boiler is in compliance with the annual emissions limit. As in the example above, the boiler derived heat input of 75,000 MMBTU from the combustion of coal in 1998; stack tests show that the boiler emitted NO_x at an average rate of 0.45 lb/MMBTU when it combusted coal. Fuel oil supplied 25,000 MMBTU during the year, and the boiler emitted NO_x at an average

rate of 0.35 lb/MMBTU when it combusted fuel oil. Natural gas supplied 100,000 MMBTU during the year, and the boiler emitted NO_x at an average rate of 0.20 lb/MMBTU when it combusted natural gas.

1. For each fuel, multiply the heat input by the average NO_x emissions rate, to calculate the quantity of NO_x that the boiler emitted when combusting each fuel in 1998:

Coal

0.45 lb/MMBTU × 75,000 MMBTU = 33,750 lbs. of NO_x.

Fuel Oil

0.35 lb/MMBTU × 25,000 MMBTU = 8,750 lbs. of NO_x.

Natural Gas

0.20 lb/MMBTU × 100,000 MMBTU = 20,000 lbs. of NO_x.

2. Add the amounts determined under paragraph 1 above to determine the quantity of NO_x emissions:

33,750 lbs. + 8,750 lbs. + 20,000 lbs. = 62,500 lbs. of NO_x.

In this example, the emissions of 62,500 pounds were less than the limit of 78,000 pounds. Accordingly, the boiler would have been in compliance.

Emergency Use of Fuel Oil

Compliance with subchapter 19 can be hindered at times by disruptions in the supply of natural gas. A combustion source that relies upon natural gas as its primary fuel, or seasonally combusts natural gas, will need to combust another fuel temporarily when the supply of natural gas is disrupted. The source may not be able to meet the NO_x emission limits that apply to sources using the backup fuel.

For this reason, when the Department proposed the existing rules it received comments suggesting an exemption from the rules for combustion sources that used liquid fuel as a backup for natural gas in an emergency. The Department agreed that an exemption was necessary, and made a commitment to amend subchapter 19 to include the exemption. The proposed new rules at N.J.A.C. 7:27-19.25 establish the conditions for the exemption.

The exemption is available only for a combustion source that uses natural gas as its primary fuel year-round, or seasonally combusts natural gas pursuant to a plan approved under N.J.A.C. 7:27-19.20. The exemption allows the use of fuel oil or other liquid fuels during the time when natural gas is unavailable.

For each day that the exemption is in effect, the combustion source is deemed to have emitted no NO_x and to have had a heat input of 0.0 BTU. As a result, there would be no violation of daily NO_x emission limits each day that the exemption is in effect. In calculating compliance with a 30-day or annual emission limit, zero NO_x emissions and heat input for the interrupted day would be factored into the calculation of the 30-day or annual average.

To qualify for the exemption, the owner or operator of the source must demonstrate (i) that he or she cannot practicably obtain a supply of natural gas sufficient to operate the source, and (ii) that the inability to obtain natural gas is due to circumstances beyond his or her control. The owner or operator must make this demonstration in a written notice to the Department within two days after the source begins using fuel oil or another liquid fuel.

The exemption ends as soon as a sufficient supply of natural gas becomes practicably available. At that time, the source must cease using the backup fuel.

The exemption limits the use of fuel oil or liquid fuel to 500 hours during any 12-month period. This limit is consistent with the exemption for emergency generators under N.J.A.C. 7:27-19.2(d) in the existing rules. The reasons behind that limit for emergency generators apply equally to sources seeking an exemption to combust backup fuels. As discussed in the Summary when the existing rules were proposed (25 N.J.R. 633, February 16, 1993), control technologies that could be installed would not yield large enough emission reductions during the restricted hours of operation to be considered RACT. In addition, it is unlikely that the exemption will jeopardize achievement of the NAAQS for ozone because curtailments of the natural gas supply occur most commonly outside the ozone season.

Phased Compliance—In General

The CAAA requires RACT to be implemented as expeditiously as practicable, but no later than May 31, 1995. EPA has provided guidance stating that a program of "phased compliance" is consistent with this requirement in certain circumstances. Under those circumstances, some action short of what would normally be full compliance will represent RACT as of May 31, 1995; the additional actions needed to attain full compliance are phased in thereafter.

Based on EPA's guidance, the proposed new rules provide for phased compliance in three circumstances:

- When a combustion source is to be repowered;
- When compliance by May 31, 1995 is impracticable; and
- When the owner or operator of a combustion source will be implementing an innovative control technology that promises greater NO_x emission reductions than required under subchapter 19, but which will not be available by May 31, 1995.

The following discussion addresses each of these circumstances and how they are handled under the proposed new rules.

Phased Compliance—Repowering

Introduction. The existing rules at N.J.A.C. 7:27-19.4(c) establish an optional alternative method for certain utility boilers to comply with subchapter 19, in lieu of complying with the emission limits in N.J.A.C. 7:27-19.4(a). The alternative compliance method is available to any utility boiler which is to be "repowered" before May 1, 1999. The existing rules define "repowering" to mean the replacement of the steam generator in the boiler. The repowered source is then subject to emissions limits that are more stringent than the limits imposed on sources of the same type that are not repowered.

There are several reasons behind the "repowering" alternative. First, if a boiler is to be operated for only a few years before being repowered, the cost of installing the necessary control measures is probably excessive compared to the emission reductions that will occur over their relatively short useful life. Second, the alternative serves as an incentive for the replacement of older, higher-polluting steam generators with newer ones that operate more efficiently; as a result of this efficiency, fuel is conserved, and a smaller quantity of pollutants is emitted in producing a given amount of output. Repowering can potentially reduce NO_x emissions from a source by more than 90 percent in most cases, compared to the 30 percent to 50 percent reductions that NO_x RACT is expected to achieve. Finally, though the repowering alternative may delay the greatest emission reductions, this delay is offset by the more stringent emission limits applicable to the source after repowering.

When the existing rules were proposed, some commenters questioned why the repowering alternative was limited to utility boilers; they suggested that the alternative be made available to non-utility boilers and other sources. The Department agreed that the reasons behind the repowering alternative apply equally to other types of sources, and therefore made a commitment to propose rules that would make this method of compliance available to all types of sources. The proposed new rule at N.J.A.C. 7:27-19.21, the proposed amendments to the definition of "repowering" at N.J.A.C. 7:27-19.1 and the proposed deletion of N.J.A.C. 7:27-19.4(c) accomplish this. The proposed amendments to the definition of "repowering" also make the rule consistent with the definition of the term in Section 402(12) of the CAAA; 42 U.S.C. 7651a(12).

After the existing rules were promulgated, EPA provided guidance confirming that states may make the repowering alternative available to sources other than utility boilers, and outlining the requirements that a source must meet in the interim period before its repowering is completed. EPA stated that its guidance regarding utility boilers could be extended to other source categories, such as stationary internal combustion engines, gas turbines and process heaters. The proposed new rules reflect EPA's guidance, discussed in more detail below.

Application requirements; repowering plan. An owner or operator seeking authorization to comply with subchapter 19 through repowering must submit an application to the Department within 30 days after the operative date of the proposed new rules; however, the Department will begin accepting applications immediately after the proposed new rules are adopted. The existing N.J.A.C. 7:27-19.4(c)3, which required the owner or operator of a utility boiler to submit this application by July 1, 1994, is proposed to be deleted; as a result, the owner or operator of a utility boiler will gain additional time to submit the application.

In addition to the general information required under N.J.A.C. 7:27-19.14 in the existing rules, the application must include a proposed repowering plan. The central requirements of the repowering plan, including the dates for completion of repowering milestones and the proposal of an "interim RACT," are discussed in more detail below.

Under the repowering plan, the replacement for the source being repowered need not be at precisely the same location. As stated in the

amended definition of "repowering" at N.J.A.C. 7:27-19.1, the replacement unit may be installed at any facility in New Jersey owned or operated by the same person who owns or operates the facility at which the source to be repowered is located. In providing for the replacement unit to be installed at another facility in New Jersey, the Department is attempting to make the rule conform to the necessities of doing business in the State, which must include the flexibility to relocate within the State. However, the Department notes that in some cases when the replacement is installed at a different facility, emission offset requirements under N.J.A.C. 7:27-19.18 may be triggered.

The replacement unit must be installed within New Jersey because if the replacement unit were installed outside the State it would not currently be possible to enforce the repowering requirements. In the future, when an interstate system of emission credit trading is developed, the Department may amend N.J.A.C. 7:27-19 to provide for the replacement unit to be installed outside the State.

Under the revised definition of "repowering," the replacement unit must have a maximum gross heat output rate that is at least 50 percent of the maximum gross heat output rate of the unit being replaced, or power output rate that is at least 50 percent of the power output rate for the unit being replaced. The purpose of requiring the unit to be replaced with something that is at least roughly equivalent is to ensure that the repowering incentive does not serve as an incentive to simply shrink operations.

Interim RACT. In its guidance, EPA has stated that a State's analysis of RACT for a source being repowered would focus upon the technical and economic feasibility of controls available over the interim period between May 31, 1995 and the repowering date. This "interim RACT" analysis is central to the repowering plan; the proposed new rules at N.J.A.C. 7:27-19.21(c)3 through 10 list the information relevant to this analysis that the owner or operator must include in the repowering plan.

The framework for establishing "interim RACT" for a repowered source closely resembles the framework for establishing facility-specific RACT under the existing rules at N.J.A.C. 7:27-19.13. The main difference between the two is that an "interim RACT" reflects the limited useful life that a control technology is likely to have in a source that will be repowered by 1999; a limited useful life results in lesser emission reductions, which means that the cost must be lower if the control technology is to be reasonable. Accordingly, the information required under the proposed new rules is essentially the same as the information required under the existing rules at N.J.A.C. 7:27-19.13.

For the same reason, the criteria that the Department will apply to arrive at an interim RACT also closely resemble the criteria for facility-specific RACT under the existing rules. In both cases, the Department must analyze several factors: the suitability of each available control measure; the NO_x emissions reductions that each available control measure can be expected to yield over its useful life; the cost of each available measure; the owner or operator's proposed rate of NO_x emissions from the source; whether that proposed rate is the lowest rate that can be achieved at a cost comparable to the cost that other similar sources will incur to comply with subchapter 19; and whether the cost of further emissions reductions would be disproportionate to their extent and impact. These criteria are set forth in the proposed new rules at N.J.A.C. 7:27-19.21(d)6 through 8.

The Department's approval of a repowering plan will include approval of an interim RACT. In accordance with EPA's guidance, the source being repowered must attain compliance with that approved interim RACT by May 31, 1995. N.J.A.C. 7:27-19.21(e)1.

The Department expects that the owners or operators of some sources will be required to annually adjust the combustion process of the source. The proposed new rules at N.J.A.C. 7:27-19.21(e)5 require this adjustment to be completed by May 1 of each calendar year beginning in 1995, in time for the beginning of ozone season. This requirement is recodified from N.J.A.C. 7:27-19.4(c)1 in the existing rules.

SIP revisions. EPA has advised that the commitment to repower and the interim RACT requirements must be submitted to EPA as a source-specific revision to the State's SIP. However, EPA has also advised that States need not submit source-specific SIP revisions if they have made these requirements federally enforceable by including them directly in their NO_x rules.

This guidance is reflected in the proposed new rules at N.J.A.C. 7:27-19.21(f) and (g). Normally, the Department will obtain public comment on a repowering plan and, if the plan is approved, submit it to EPA as a proposed SIP revision. However, if a repowering plan provides for NO_x emissions from a source to be controlled either by seasonal fuel switching or by the use of selective non-catalytic reduction (through which NO_x is controlled by injecting a reducing agent such as ammonia, urea or cyanuric acid into the flue gas; the reducing agent converts NO_x to molecular nitrogen, water, and possibly carbon dioxide), the Department will not submit the repowering plan to EPA as a SIP revision for that source. As discussed in the Summary of the proposal of the existing rules (25 N.J.R. 631, February 16, 1993), the Department has determined that the reductions in NO_x emissions that can be expected from these control methods meet the RACT requirements of the 1990 CAAA.

Requirements following repowering. Under EPA's guidance, after a source has been repowered it must meet applicable requirements for new sources. In accordance with that guidance, the proposed new rules at N.J.A.C. 7:27-19.21(e)8 require the owner or operator to incorporate advances in the art of air pollution control into each source that is repowered.

In addition, the existing rules at N.J.A.C. 7:27-19.4(c) establish the NO_x emission limits that utility boilers must meet after they have been repowered; however, if advances in the art at the time of repowering would make a boiler capable of meeting more stringent NO_x emission limits, the boiler would be required to do so. Those limits are recodified at N.J.A.C. 7:27-19.21(e), and continue to apply to utility boilers that are repowered.

Enforceable commitment to repower. In its utility boiler guidance, EPA has stated that an owner or operator intending to repower a boiler must make an enforceable commitment to do so by May 1, 1999. The requirements for this enforceable commitment are included in the proposed new rules at N.J.A.C. 7:27-19.21(h) and applied to owners and operators intending to repower any type of combustion source.

Under those provisions, the owner or operator of the source to be repowered will enter into an agreement with the Department requiring the owner or operator to repower the source by a specified date. The date must be no later than May 1, 1999. If the source has not been repowered by May 1, 1999, the source must cease operating by that date.

EPA has also stated that the enforceable commitment must include dates on which intermediate milestones for repowering must be completed. Those milestones include the awarding of contracts for the repowering project and the purchase of component parts, and the date on which construction and/or installation is to begin. Under the proposed new rules at N.J.A.C. 7:27-19.21(c)2, the owner or operator includes the proposed dates for achieving those milestones in the repowering plan. The repowering plan also includes an additional milestone: obtaining all necessary permits and certificates. The Department has included this additional milestone because all of the other milestones depend upon it; accordingly, it will assist the Department and the owner or operator in setting realistic dates for the other milestones. The owner or operator will be required to complete the milestones by the approved dates, under its agreement with the Department and under the Department's approval of the repowering plan.

Under the agreement that the owner or operator and the Department will sign, the Department may terminate the agreement and the approval of the repowering plan if the owner or operator materially fails to complete the repowering or any other milestone by the date specified in the approved plan. If the agreement and approval are terminated, the combustion sources covered by the repowering plan would become subject to the NO_x emission limits established elsewhere in subchapter 19, and would be risking enforcement action and penalties if they exceeded those limits. The Department would not expect to exercise this remedy unless less formal efforts to bring the repowering back on schedule had failed.

Sources to be retired. When subchapter 19 was originally proposed, it allowed sources that were to be shut down by April 30, 1999 to comply with the rules in the same manner as sources that were to be repowered by that date. However, EPA provided guidance stating that this provision was inconsistent with the requirements of the CAAA. Accordingly, the provision for sources to be shut down was deleted upon adoption.

Nonetheless, the Department recognizes that the limited useful life of a source that is to be shut down makes some types of control techniques economically unfeasible. For this reason, it will normally be advisable for the owner or operator of such a source to seek approval of a facility-specific NO_x control plan under N.J.A.C. 7:27-19.13. The Department will consider the remaining useful life in evaluating such a NO_x control plan.

As discussed above, an incentive for repowering is consistent with the purpose of subchapter 19, because repowering replaces older, higher-

polluting steam generators with newer ones that conserve fuel and emit a smaller quantity of pollutants. However, an incentive to retire sources would not serve the purposes of subchapter 19 or the broader public policies of the State. Accordingly, the proposed new rules do not include such an incentive.

Phased Compliance—Impracticability of Full Compliance by May 31, 1995

As discussed above, under the CAAA New Jersey must require RACT to be implemented as expeditiously as practicable, but no later than May 31, 1995. In most cases, only compliance with the NO_x emission limits in this subchapter will satisfy the RACT requirement. However, some combustion sources will not practicably be able to attain full compliance with those limits in the period between December 20, 1993 (the date on which subchapter 19 was promulgated) and May 31, 1995, despite the best efforts of the owners and operators of those sources.

For those sources, full compliance with the applicable NO_x emission limit is not considered RACT on May 31, 1995; full compliance will be considered RACT at a later date that depends upon each source. The proposed new rules at N.J.A.C. 7:27-19.22 address this issue by enabling an owner or operator to meet the RACT requirement by complying with a plan for phased compliance. Phased compliance under the plan begins on May 31, 1995, and is completed at a specified date thereafter.

Application. An owner or operator seeking approval of a phased compliance plan must apply to the Department within 30 days after these amendments become operative. N.J.A.C. 7:27-19.22(b). In that application, the owner or operator will describe the efforts taken to bring each combustion source into full compliance by May 31, 1995, and the circumstances that make full compliance by that date impracticable. The application also includes the proposed phased compliance plan itself.

One key part of the phased compliance plan is the proposed schedule for bringing each combustion source into full compliance. N.J.A.C. 7:27-19.22(c)2. The milestones are essentially the same as the milestones under a repowering plan, discussed in the summary of N.J.A.C. 7:27-19.21 above. The other key to the phased compliance plan is the NO_x control measures or technology that the owner or operator proposes to employ from May 31, 1995 until full compliance is achieved. N.J.A.C. 7:27-19.22(c)3.

Criteria for approval. The Department will approve or disapprove a phased compliance application based on criteria listed in N.J.A.C. 7:27-19.22(d).

The application must first establish that the owner or operator made a good faith effort to bring each combustion source into compliance by May 31, 1995. N.J.A.C. 7:27-19.22(d)2. This requirement is necessary to avoid giving a competitive advantage to owners and operators who delayed compliance and penalizing those who worked to comply promptly.

The application must then establish that full compliance with the applicable NO_x emission limit by May 31, 1995 is impracticable. N.J.A.C. 7:27-19.22(d)3. Any of several factors may make timely compliance impracticable:

- The owner or operator may need to obtain a permit from the Department before beginning to construct or install the necessary control measures; the time needed to process certain permit applications may make it impracticable to complete the construction or installation on time.
- As owners and operators work to comply with the May 31, 1995 deadline, they may be competing for a limited supply of component parts and equipment needed to attain compliance. The resulting shortages may delay shipments of the parts and equipment, making it impracticable to complete the necessary construction or installation on time.
- The construction or installation itself may be too time-consuming to practicably complete on time.
- Timely compliance may require measures that will pose a risk to public safety or welfare. For example, an electric generating utility might be able to attain timely compliance only by simultaneously taking a large number of electric generating units out of service to install the necessary control technology; voltage reductions or interruptions in electric service could result. The Department will consider such risks in evaluating practicability.

Finally, the application must propose a date for full compliance that is no later than May 31, 1996. The Department expects that the additional year will be enough for almost all combustion sources to practicably attain full compliance. If an owner or operator seeks additional time, the Department will consider exercising its enforcement discretion case-by-case and possibly enter into an administrative consent order with the owner or operator.

Interim control measures. The proposed new rules at N.J.A.C. 7:27-29.22(g)4 describe the NO_x control measures that the owner or operator must take in the interim period between May 31, 1995 and the full compliance date. The Department has determined that the use of one of these measures represent RACT in light of the limited length of time (no more than 12 months) over which they will be used.

For boilers and other combustion sources from which NO_x emissions can be reduced by adjusting the air-to-fuel ratio in the combustion process, the owner or operator will be required to make those adjustments until the deadline for reaching full compliance. For sources that are not amenable to this type of tune-up, the owner or operator can employ seasonal fuel switching under N.J.A.C. 7:27-19.20, or selective non-catalytic reduction (through which NO_x is controlled by injecting a reducing agent such as ammonia, urea or cyanuric acid into the flue gas; the reducing agent converts NO_x to molecular nitrogen, water, and possibly carbon dioxide) to control NO_x emissions until the deadline. In addition, an owner or operator may use another control measure that the Department finds appropriate, based on the costs involved and the quantity of NO_x reductions that will be achieved.

Phased Compliance—Innovative Control Technology

In discussions with the Department, EPA has advised that in certain cases RACT may include a phased program extending beyond May 31, 1995, for sources that are actively developing innovative control technology. The use of a phased program will create incentives for the use of innovative technology that promises significant environmental benefits. Based on that guidance, the Department is proposing a new rule at N.J.A.C. 7:27-19.23 that will govern plans for phased compliance to allow owners and operators to implement innovative control technology.

A phase-in of compliance to allow innovative control technology to be used is similar to phased compliance for repowering. In both scenarios, by May 31, 1995 the combustion source is not expected to attain full compliance with the NO_x emission limits established elsewhere in subchapter 19. Instead, the source is expected to achieve greater NO_x emission reductions at a later date.

For this reason, the proposed new rule for innovative control technology at N.J.A.C. 7:27-19.23 is analogous in many ways to the proposed new rule for repowering at N.J.A.C. 7:27-19.21.

Innovative control technology. Proposed amendments to N.J.A.C. 7:27-19.1 define "innovative control technology." A NO_x control measure is "innovative control technology" if it has a substantial likelihood of achieving greater continuous NO_x emissions reductions than are required to meet the emission limits under subchapter 19, but has not been adequately demonstrated and is not available to be implemented before May 31, 1995. A control measure will not meet this standard if it promises only marginally better NO_x emission reductions than are required to meet the emission limits under subchapter 19. "Innovative control technology" includes a variety of control measures, including an item of equipment or control apparatus, a change in a process, or a pollution prevention strategy.

Application requirements; innovative control technology plan. An owner or operator seeking authorization to phase in compliance through the use of innovative control technology must submit an application to the Department within 30 days after the operative date of the proposed new rules. However, the Department will begin accepting applications immediately after the proposed new rules are adopted.

The application requirements under this section are similar to the application requirements for sources to be repowered under N.J.A.C. 7:27-19.21, discussed above. The main difference is the information regarding the proposed innovative control technology. The owner or operator must describe the proposed innovative control technology; estimate the rate of NO_x emissions that the combustion source will be able to attain when it employs the control technology; explain the basis for that estimate; and establish that the control technology is technically sound and sufficiently developed to be implemented by May 1, 1999. N.J.A.C. 7:27-19.23(c)2, 3 and 4.

Interim RACT. As is the case under the repowering rules, the innovative control technology rules require the owner or operator to implement "interim RACT" NO_x control measures during the interim period between May 31, 1995 and the date on which the innovative control technology must be fully implemented. In determining what interim control measures are economically and technologically feasible,

the Department will consider the limited useful life that a control measure is likely to have in a source that will be employing different control measures by 1999.

The application requirements relevant to interim RACT, and the criteria that the Department will apply to arrive at an interim RACT, are essentially identical to the corresponding requirements in the repowering rules. As is also the case under the repowering rules, the source in question must attain compliance with that approved interim RACT by May 31, 1995. N.J.A.C. 7:27-19.23(e)1.

SIP revisions. Based on discussions with EPA, the Department believes that the phased compliance plan and the interim RACT requirements must be submitted to EPA as a revision to the State's SIP following an opportunity for public comment. However, these requirements need not be submitted as source-specific SIP revisions if the requirements are included directly in the NO_x rules.

Accordingly, N.J.A.C. 7:27-19.21(f) provides that the phased compliance plan will normally be submitted to EPA as a proposed SIP revision; however, if the plan provides for NO_x emissions from the source to be controlled either by seasonal fuel switching or by the use of selective non-catalytic reduction, the Department will not submit the repowering plan to EPA as a SIP revision for that source. As discussed in the Summary of the proposal of the existing rules (25 N.J.R. 631, February 16, 1993), the Department has determined that the reductions in NO_x emissions that can be expected from these control methods meet the RACT requirements of the 1990 CAAA.

Enforceable commitment to implement innovative control technology. The proposed new rules require the owner or operator to make an enforceable commitment to implement the innovative control technology by May 1, 1999. The requirements for this enforceable commitment are included in the proposed new rules at N.J.A.C. 7:27-19.23(h), and are essentially the same as the corresponding requirements in the repowering rules at N.J.A.C. 7:27-19.21(h).

Maximum Emergency Generation

Introduction. In commenting upon the original proposal of subchapter 19, Public Service Electric and Gas (PSE&G) suggested that the rule should recognize that electric generating utilities sometimes operate in a "maximum emergency generation" (MEG) mode. 25 N.J.R. 5961, Comment 36 (December 20, 1993). In this mode, a utility is providing the last increment of power generation available prior to voltage reductions and service interruptions. PSE&G noted that in the three years preceding its comment, it has responded to MEG alerts for a total of only 16.2 hours.

Utilities operate at MEG at the direction of the "load dispatcher" acting on behalf of the Pennsylvania-New Jersey-Maryland Interconnection (PJM). PJM is a combination of eight electric generating utilities, linked physically and through contractual arrangements, for coordinated planning and operation in the region served by PJM's member utilities. Those utilities serve approximately 97 percent of New Jersey, parts of Maryland, Pennsylvania and Virginia, and all of Delaware and the District of Columbia.

The load dispatcher is responsible for selecting the most economically available generating units throughout the PJM system, to meet the daily forecasted peak demand of the eight member companies. In meeting high levels of demand for electricity, or to compensate for an electric generating unit that is out of service, each member company of PJM can rely upon the capacity of the other companies. Conversely, in imposing a "MEG alert," the load dispatcher may call upon a member company to operate at levels in excess of the normal maximums in order to help meet the needs of other member companies.

The load dispatcher most frequently calls for MEG alerts during the summer ozone season, when air conditioners and other cooling equipment strain electric generating capacity. Less frequently, a MEG alert may occur during bitterly cold weather such as that which the State experienced in January 1994.

The Department recognizes that when a utility boiler or other source used in generating electricity is operating beyond its normal maximum capacity during a MEG alert, its rate of NO_x emissions is likely to increase significantly. For this reason, an inflexible requirement to reduce NO_x emissions during a MEG alert may hinder a utility's ability to provide uninterrupted electric service to customers. Failure to meet the full demand for electricity can pose a risk to the security and safety of the utility's customers. This risk must be balanced against the possible impact of uncontrolled NO_x emissions on air quality; however, that balance is affected by the relatively infrequent occurrences of MEG alerts, and the availability of other measures to minimize impacts on air quality without deterring utilities from providing uninterrupted electric service.

N.J.A.C. 7:27-19.24 therefore provides that when an electric generating utility operates a source at emergency capacity during a MEG alert, that source is exempt from the emissions limits that would otherwise be applicable under subchapter 19. A discussion of the details of this exemption follows.

Definitions. The MEG alert exemption is available only for electric generating units. The proposed amendments to N.J.A.C. 7:27-19.1 define "electric generating unit" to include any combustion source that is owned or operated by an electric generating utility and used to generate electricity for commercial sale. For example, a stationary gas turbine used to generate electricity or a utility boiler would be included within the definition of "electric generating unit."

During a MEG alert, an electric generating unit is operated at "emergency capacity." Emergency capacity is the generation of electricity at a rate in excess of the unit's maximum normal power output rating. That rating is the subject of an agreement between PJM and each electric generating utility. The rating for each electric generating unit is published by the utility.

The proposed amendments to N.J.A.C. 7:27-19.1 define "MEG alert." The alert is the period in which the utility operates one or more electric generating units at emergency capacity in order to prevent or mitigate voltage reductions and/or interruptions in electric service. The alert begins when the utility begins to operate one or more electric generating units at emergency capacity after receiving notice from the load dispatcher, directing the utility to do so. The alert ends when the utility ceases operating its electric generating units at emergency capacity.

Effect of MEG alert. During the MEG alert, any electric generating unit operated at emergency capacity is exempt from the NO_x emissions limit that would otherwise apply. N.J.A.C. 7:27-19.24(a). To preserve the exemption, the electric generating utility must comply with reporting requirements and emissions credit requirements, discussed below.

Emission reduction credits; reporting. Under N.J.A.C. 7:27-19.24(c), the utilities will be required to compensate for the excess NO_x emissions (that is, emissions in excess of what would have been authorized under the emissions limits that would have been applicable in the absence of the MEG exemption) emitted during MEG alerts. The utility will make that compensation by reducing NO_x emissions from a combustion source above and beyond the reductions required under any Federal or State law, rule, regulation, permit or order. The ratio of the compensating emissions reductions to the excess emissions that occurred during the MEG alert must be at least 1.3:1. The Clean Air Act uses this ratio in Section 182(d)(2), concerning emission offset requirements. The circumstance addressed by that provision of the Clean Air Act is similar to the MEG alert situation; accordingly, the Department believes that this provision is helpful in determining the appropriate level of compensating emission reductions for MEG alerts.

N.J.A.C. 7:27-19.24(b) describes the report that the utility is required to submit to the Department within two working days after the MEG alert ends. The report contains information relevant to the compensation requirement, such as a calculation of the excess NO_x emissions from each electric generating unit that operated at emergency capacity during the MEG alert. The report also states when the MEG alert began and ended.

One utility that participated in the rule development working group stated that no compensation for excess NO_x emissions during MEG alerts should be required. The utility noted that when it operates a source at emergency capacity to meet electricity demand during a MEG alert, it is acting prudently and in the best interest of the community, business and industry.

The Department agrees with this reasoning, but disagrees with the conclusion. The reasons that the utility cites are the same reasons supporting the Department's decision to exempt an electric generating unit from NO_x emission limits when the unit is operated at emergency capacity during a MEG alert. The need to meet electricity demand during the alert outweighs the need to control NO_x emissions from the unit in question at the same time; to avoid deterring utilities from meeting electricity demand, it is necessary to eliminate the risk that they would be liable for violations of air pollution control laws. The compensation requirement enables the Department to promote the protection of air quality without creating a deterrent to meeting electricity demand.

Expiration. The MEG alert exemption is available only for MEG alerts that occur on or before November 15, 2005. That date is the primary standard attainment date for ozone established under section 181(a)1

of the Clean Air Act for much of the State. The Department expects that extending the MEG alert exemption beyond that date would hinder the State's effort to reach attainment by that date. The 10-year life of the exemption will allow for modifications to electric generating units that can eliminate the need for the exemption.

Other Amendments

Recordkeeping and reporting. The proposed amendments to N.J.A.C. 7:27-19.19 establish recordkeeping requirements for owner or operator of a combustion source that is:

- Included in a fuel switching plan approved under N.J.A.C. 7:27-19.14 and 19.20;
- Included in a plan for phased compliance approved under N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21 or 19.23; or
- Temporarily combusting fuel oil or other liquid fuel in place of natural gas, pursuant to N.J.A.C. 7:27-19.25.

The proposed amendments also establish reporting requirements for the first two classes of sources, but not for sources temporarily combusting liquid fuel. In light of the intermittent and brief nature of the temporary liquid fuel combustion, the Department does not believe that reporting is necessary to verify compliance with N.J.A.C. 7:27-19.25.

Under the proposed recordkeeping requirements, the owner or operator must record the amount, type and higher heating value of each fuel that the source consumes, and the quantity of NO_x that the source emits. During the ozone season, these records must be maintained on a daily basis; at other times of the year, the records must be maintained on the basis of a rolling 30-day average (that is, each 30-day period ending on September 16 and on each subsequent day until the following April 30).

The records during the ozone season must state whether the source complied with the limit on the rate of NO_x emissions each day. Outside the ozone season, the record need only state whether the total quantity of NO_x emissions each 30-day period complied with the applicable limit.

By October 30 of each year, the owner or operator must submit to the Department a report regarding the ozone season of that year. The report includes the information set forth in the records. N.J.A.C. 7:27-19.19(g).

N.J.A.C. 7:27-19.19(h) requires the owner or operator of the source to submit an annual report for each calendar year. The report includes the information set forth in the records; in addition, for each combustion source included in a fuel switching plan, the report includes a determination whether the source complied with the annual limit on NO_x emissions. The owner or operator must submit the report by March 1 of the following year. The owner or operator need not include in the annual report the information already submitted in the October 30 report.

Exemptions. Under N.J.A.C. 7:27-19.2(f) in the existing rules, the owner or operator of a facility may apply for an exemption from subchapter 19. A facility is not eligible for the exemption unless its daily potential to emit NO_x on any day from May 15 through September 15 is less than 137 pounds per day. The proposed amendments revise this exemption by changing May 15 to May 1. This change is consistent with the delineation of the ozone season throughout subchapter 19. The Department believes that May 1 is the appropriate starting date for the ozone season; in 1993, two exceedances of the ozone NAAQS occurred between May 1 and May 15.

Indirect heat exchangers. The proposed amendments to N.J.A.C. 7:27-19.1 define "indirect heat exchanger" to mean equipment in which heat from the combustion of fuel is transferred by conduction to a substance being heated, so that the substance being heated is not contacted by the products of combustion and adds nothing to them. The definition in the proposed amendments is identical to the definition of "indirect heat exchanger" in the existing rules at N.J.A.C. 7:27-6.1, except that the definition in subchapter 19 makes it clear that process heaters and duct burners are considered indirect heat exchangers.

A boiler is a type of indirect heat exchanger which generates steam. Other types of indirect heat exchangers (such as process heaters) differ in their purpose, but their combustion processes that emit NO_x are similar to the combustion processes in boilers. For this reason, the Department believes that the NO_x emission limits established in the existing rules for non-utility boilers are equally applicable to other types of indirect heat exchangers as well. The proposed amendments therefore expressly make these limits applicable to all indirect heat exchangers. For example, many petroleum refineries employ process heaters that are subject to subchapter 19; those process heaters will be subject to the NO_x emission limits set forth in N.J.A.C. 7:27-19.7.

The Department stresses that this amendment does not expand the scope of subchapter 19. Any indirect heat exchanger that is not regulated under subchapter 19 as it currently stands will remain unregulated. However, many indirect heat exchangers are currently subject to subchapter 19. In the absence of standardized requirements for these sources, their owners and operators must obtain approval of facility-specific NO_x emission limits under N.J.A.C. 7:27-19.13.

By applying standardized NO_x emission limits to these sources under N.J.A.C. 7:27-19.7, the proposed amendments will simplify compliance with subchapter 19 for many owners and operators of the sources. The proposed amendments do not limit the flexibility of those owners and operators in complying with subchapter 19, because they will still have the option of developing facility-specific NO_x emission limits under N.J.A.C. 7:27-19.13 as they do under the existing rules.

Annual tune-ups. The existing rules at N.J.A.C. 7:27-19.7(a) required the owner or operator of a non-utility boiler with a maximum gross heat input rate between 20 million and 50 million BTUs per hour to begin annual tune-ups of the combustion process beginning in calendar year 1994. The proposed amendments revise this requirement in three ways.

First, the owner or operator may elect to forgo the annual tune-ups, and instead comply with the emission limits in N.J.A.C. 7:27-19.7, Table 4. Compliance with those limits would be established through continuous emissions monitoring. This option adds flexibility to the rule without sacrificing protection of air quality.

Second, annual tune-ups will be required for any non-utility boiler or other indirect heat exchanger with a maximum gross heat input rate between 50 million and 250 million BTUs per hour, unless such NO_x emissions from the unit are monitored by a continuous emissions monitoring system. The purpose of this requirement is to ensure that the NO_x control measures installed on such units are performing adequately. N.J.A.C. 7:27-19.7(d).

Third, for non-utility boilers the date for beginning tune-ups is being postponed from calendar year 1994 to calendar year 1995. The Department believes that it should have more widely publicized the 1994 tune-up requirement in the existing rules to make the regulated community more fully aware of the requirement. Many of the smaller boilers affected by the requirement are operated by small businesses which may have been unaware of the requirement, especially since it differed from the more widely publicized CAAA compliance deadline of May 31, 1995.

Use of refinery fuel gas. When a refinery produces petroleum products, one by-product is a gas that can be used for fuel. The proposed amendments use the term "refinery fuel gas" to refer to this fuel. The term is defined at N.J.A.C. 7:27-19.1. The definition refers to gas derived from the "refining process," which is in turn defined in essentially the same manner as in N.J.A.C. 7:27-25.1.

The proposed amendments to N.J.A.C. 7:27-19.7 establish NO_x emission limits for indirect heat exchangers that are combusting this gas. The Department arrived at these emissions limits following discussions with the New Jersey Petroleum Council (NJPC), which participated in the rule development working group and provided relevant information for the Department's review.

For indirect heat exchangers with a maximum gross heat input rate of at least 100 MMBTU/hr, combusting refinery fuel gas, NJPC recommended a maximum NO_x emission rate of 0.2 lb/MMBTU. That limit is the same as the limit in the existing rules for gas-fired indirect heat exchangers of the same size. For smaller indirect heat exchangers combusting refinery fuel gas, NJPC recommended the same limit. However, that limit is less stringent than the limit of 0.2 lb/MMBTU applied to gas-fired indirect heat exchangers of the same size.

NJPC recommended this less stringent limit because variations in the composition of refinery fuel gas (such as the concentration of hydrogen or of heavy hydrocarbons), as well as variations in temperature and pressure, make it unlikely that the smaller indirect heat exchangers could consistently meet the 0.1 lb/MMBTU limit. In addition, existing NO_x control technologies are not sufficient to enable indirect heat exchangers combusting refinery fuel gas to meet the limit of 0.1 lb/MMBTU.

The Department agrees with NJPC's reasoning, and has incorporated the 0.2 lb/MMBTU limit into the proposed amendments.

Clarification of facility-specific NO_x emission limits. N.J.A.C. 7:27-19.13(a)1 states that a facility-specific NO_x emission limit is necessary if a major NO_x facility "contains any source operation or item of equipment not listed in N.J.A.C. 7:27-19.2(b) which has the potential to emit more than 10 tons of NO_x per year." Some confusion about this provision has arisen. N.J.A.C. 7:27-19.2(b) lists types of sources, and

states that each type is subject to subchapter 19 based on cutpoints regarding a particular source's output, heat input, productive capacity or potential to emit NO_x.

In promulgating N.J.A.C. 7:27-19.13(a)1, the Department did not intend to require facility-specific NO_x emission limits for a type of source that is listed in N.J.A.C. 7:27-19.2(b), but falls below the applicable cutpoint. For example, N.J.A.C. 7:27-19.2(b)2 lists non-utility boilers with a maximum gross heat input rate of at least 20 million BTUs per hour; the Department did not intend that a non-utility boiler with a maximum gross heat input rate of 15 million BTUs per hour would be obtaining a facility-specific NO_x emission limit. The Department intended that N.J.A.C. 7:27-19.13(a)1 would encompass only sources that were not among the types listed in N.J.A.C. 7:27-19.2(b). The proposed amendments clarify this point.

Penalties. N.J.A.C. 7:27A-3.10 establishes civil administrative penalties for violations of rules adopted pursuant to the Air Pollution Control Act. The proposed amendments to N.J.A.C. 7:27A-3.10(e)19 revise the penalty schedule to reflect the proposed amendments and new rules in subchapter 19. In establishing the proposed penalty amounts, the Department has applied the following criteria:

1. The potential or actual health and environmental impacts of the violation, including the characteristics and quality of the air contaminants regulated, the magnitude of the areas affected and the air quality of the area affected;

2. The deterrent value of the penalty and whether the proposed penalty amounts are appropriate to ensure compliance with N.J.A.C. 7:27-19; and

3. Consistency with penalties in N.J.A.C. 7:27A-3 for violations of other comparable rules in N.J.A.C. 7:27. For example, the penalties for violations of emission limits established under N.J.A.C. 7:27-19 correspond to penalties for violations of emission limit under N.J.A.C. 7:27-8 for source operations in similar source categories. Penalties for violation of recordkeeping, reporting requirements, source testing and requirement to submit reports correspond to existing penalty amounts in N.J.A.C. 7:27A for similar violations of N.J.A.C. 7:27. Except as indicated, the following table below shows the provisions of N.J.A.C. 7:27-19 for which a penalty for violation is proposed, and the rules which have comparable requirements in N.J.A.C. 7:27 and comparable penalty in N.J.A.C. 7:27A-3.

Provisions of subchapter 19 for which a penalty for violation is proposed:	Provision of existing rules with corresponding penalty for comparable violation:
N.J.A.C. 7:27-19.3(d)	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.7(d)	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.15(c)	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.19(d)	N.J.A.C. 7:27-16.16(g)
N.J.A.C. 7:27-19.19(e)	N.J.A.C. 7:27-16.13(c)
N.J.A.C. 7:27-19.19(g)	N.J.A.C. 7:27-16.18(j)2
N.J.A.C. 7:27-19.19(h)	N.J.A.C. 7:27-16.18(j)2
N.J.A.C. 7:27-19.19(i)	N.J.A.C. 7:27-16.18(j)2
N.J.A.C. 7:27-19.20(d)	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.20(g)1	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.20(g)2	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.20(g)3	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.20(g)4	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.20(g)5	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.20(i)1, 2 or 3	N.J.A.C. 7:27-16.16(g)
N.J.A.C. 7:27-19.21(e)1	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.21(e)2	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.21(e)4	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.21(e)5	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.21(e)6	N.J.A.C. 7:27-16.16(g)
N.J.A.C. 7:27-19.21(e)7	N.J.A.C. 7:27-17.5(e)
N.J.A.C. 7:27-19.21(e)9	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.21(e)10	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.22(g)1	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.22(g)2	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.22(g)3	N.J.A.C. 7:27-17.5(e)
N.J.A.C. 7:27-19.22(g)4	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)1	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)2	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)3	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)4	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)5	N.J.A.C. 7:27-8.3(e)1 or (e)2
N.J.A.C. 7:27-19.23(e)6	N.J.A.C. 7:27-16.16(g)
N.J.A.C. 7:27-19.23(e)7	N.J.A.C. 7:27-17.5(e)
N.J.A.C. 7:27-19.23(e)9	N.J.A.C. 7:27-8.3(e)1
N.J.A.C. 7:27-19.24(b)	N.J.A.C. 7:27-16.18(j)2
N.J.A.C. 7:27-19.25(d)	N.J.A.C. 7:27-17.5(e)

Social Impact

The proposed amendments and new rules will enhance the positive social impact of the existing rules at N.J.A.C. 7:27-19. That impact is discussed in the original proposal of subchapter 19 (see 25 N.J.R. 642 (February 16, 1993)) and includes a reduction in damage from acid rain and ozone exposure.

Part of the added social benefit is due to the increased flexibility under the proposed amendments and new rules. The provisions for seasonal fuel switching and phased compliance make subchapter 19 more flexible by creating alternative ways to comply with subchapter 19. As a result, owners and operators can choose the approach to compliance that minimizes any adverse social impacts.

Additional social benefit will result from the provisions governing MEG alerts and emergency use of fuel oil. Those provisions address circumstances in which some owners and operators could not comply with subchapter 19 without compromising another important social goal. The MEG alert exemption will have a positive social impact, because it will avoid deterring electric generating utilities from meeting peak demands for electricity. The exemption for emergency use of fuel oil will have a positive social impact because it will avoid penalizing industries that cannot comply with subchapter 19 when the supply of natural gas is curtailed.

The proposed amendments to N.J.A.C. 7:27-19.7, which establish NO_x emission limits for indirect heat exchangers, will have a positive social impact. Under the existing rules, an owner or operator of an indirect heat exchanger subject to subchapter 19 must obtain approval of a facility-specific NO_x control plan; the proposed amendments contain standardized NO_x control requirements for these sources, so that the owner or operator can avoid the paperwork associated with a facility-specific NO_x control plan.

The proposed amendments to N.J.A.C. 7:27A-3.10(e) will have a positive social impact, by encouraging compliance and discouraging noncompliance with the State's air pollution control laws and regulations.

Economic Impact

The Department expects the proposed amendments and new rules to have a primarily positive economic impact. In general, the proposed amendments and new rules do not impose new regulatory requirements upon the owners and operators of combustion sources regulated under subchapter 19. Instead, most of the proposed amendments and new rules fall into two categories:

- Establishing alternative means of complying with subchapter 19, thereby allowing owners and operators to choose the approach to compliance that makes the most economic and business sense; and
- Recognizing circumstances in which some owners and operators could not have practicably complied with subchapter 19, and making it possible for those owners and operators to avoid violating subchapter 19 and risking enforcement action and penalties.

New rules in the first category include expanding eligibility to seasonally combust cleaner fuels and to repower. The first category also includes phased compliance to allow the use of innovative control technology. An owner or operator will have the option of either using one of these alternative means of compliance or complying with the NO_x emission limits already present in the existing rules. Since the owner or operator is not required to repower or to use clean fuels seasonally, the Department expects that these options will normally be employed when they will reduce compliance costs. As a result, the proposed amendments and new rules will have a positive economic impact upon owners and operators who can reduce their compliance costs in one of these ways; the proposed amendments and new rules will have no economic impact upon owners and operators who choose instead to comply with the emission limits in the existing rules.

New rules in the second category include allowing emergency use of fuel oil, allowing exceedance of emission limits during MEG alerts, and allowing phased compliance when full compliance by May 31, 1995 would be impracticable. If subchapter 19 did not provide for emergency use of fuel oil, owners and operators of gas-fired combustion sources almost certainly would exceed NO_x emissions limits at times when the supply of natural gas is curtailed. If subchapter 19 did not provide for MEG alerts, electric generating utilities would frequently exceed NO_x emissions limits at times of peak electricity demand. If subchapter 19 did not

provide for phased compliance, a variety of combustion sources would almost certainly be unable to meet the applicable NO_x emission limits on May 31, 1995. As a result, the proposed new rules will have a positive economic impact upon owners or operators who could otherwise have been subject to enforcement action and penalties.

The economic impact of subchapter 19 upon each type of source that it regulates is discussed in detail in the original proposal of subchapter 19. 25 N.J.R. 642-644 (February 16, 1993). A discussion of the economic impact of each change under the proposed amendments and new rules follows:

Seasonal Fuel Switching

In lieu of complying with the NO_x emission limits in the existing rules, the owner or operator of a combustion source may elect to comply with subchapter 19 through seasonal fuel switching pursuant to N.J.A.C. 7:27-19.20. The primary reason for an owner or operator to elect this alternative method of compliance is to avoid incurring the initial capital costs and operating costs associated with installing and operating the control measures that would be necessary to comply with the NO_x emission limits. Accordingly, the Department expects that the proposed new rule at N.J.A.C. 7:27-19.20 will have a positive economic impact upon an owner or operator who chooses to comply with subchapter 19 through seasonal fuel switching.

The extent of that positive economic impact depends primarily upon the following factors:

- The initial capital costs and operating costs of complying with the NO_x emission limits in the existing rules, as discussed in the original proposal of subchapter 19;
- The cost of the fuels that the combustion source is currently combusting;
- The particular cleaner fuel that the owner or operator chooses to combust seasonally;
- The cost of each type of fuel that is currently combusted, and the cost of each type of fuel that will be combusted under seasonal fuel switching;
- The quantity of each type of fuel that is currently combusted, and the quantity of each type of fuel that will be combusted under seasonal fuel switching; and
- The extent to which the combustion source can meet the annual emission limits, the daily emission limits during ozone season, and the 30-day rolling average emission limits outside the ozone season, without installing and operating additional control technology.

The Department expects these factors to vary substantially among any class of combustion sources. The cost of fuel is variable as well. For this reason, the Department cannot quantify the range of cost savings that will result from seasonal fuel switching.

An owner or operator electing to use seasonal fuel switching will also incur some minor costs in obtaining the Department's approval of a fuel switching plan, and maintaining that approval in effect.

Repowering

The owner or operator of a combustion source that is to be repowered by May 1, 1999 may comply with the repowering incentive provisions at N.J.A.C. 7:27-19.21 in lieu of complying with the NO_x emission limits in the existing rules. The purpose of the repowering provisions is to allow an owner or operator to avoid incurring the initial capital costs and operating costs associated with installing and operating control measures that will not be justified over the relatively short useful life that will result from the repowering. Accordingly, the Department expects that the proposed new rule at N.J.A.C. 7:27-19.21 will have a positive economic impact upon an owner or operator who is planning to repower a combustion source.

The extent of that positive economic impact depends primarily upon the following factors:

- The initial capital costs and operating costs of complying with the NO_x emission limits in the existing rules, as discussed in the original proposal of subchapter 19;
- The nature and cost of the control measures needed to meet the interim NO_x emission limits established under the repowering plan, or other requirements established under the plan;
- The nature and cost of the control measures that will represent advances in the art of air pollution control when the source is repowered; and
- The extent of the saving in fuel consumption that will result from increased combustion efficiency after repowering is completed.

Innovative Control Technology

The owner or operator of a combustion source that will employ innovative control technology may comply with the phased compliance provisions at N.J.A.C. 7:27-19.23 in lieu of complying with the NO_x emission limits in the existing rules. The phased compliance provisions allow an owner or operator to avoid incurring the initial capital costs and operating costs associated with installing and operating control measures that will not be justified over the relatively short useful life that will result from the repowering. The prospect of avoiding those costs should encourage innovative control technology. Accordingly, the Department expects that the proposed new rule at N.J.A.C. 7:27-19.21 will have a positive economic impact upon an owner or operator who is planning to employ innovative control technology.

The extent of that positive economic impact depends primarily upon the following factors:

- The initial capital costs and operating costs of complying with the NO_x emission limits in the existing rules, as discussed in the original proposal of subchapter 19;
- The nature and cost of the control measures needed to meet the interim NO_x emission limits established under the phased compliance plan, or other requirements established under the plan; and
- The nature of the innovative control technology and the cost of constructing, installing and operating it.

Phased Compliance—Impracticability of Compliance by May 31, 1995

Under the proposed new rule at N.J.A.C. 7:27-19.22, the owner or operator of a combustion source that cannot practicably attain full compliance with the applicable NO_x emission limits by May 31, 1995 can instead begin phasing in compliance on that date. In proposing to allow this phased compliance, the Department is recognizing that in some cases, it may be impracticable for an owner or operator to attain compliance by May 31, 1995, and is providing an alternative to noncompliance. The Department expects this approach to have a positive economic impact, as discussed below.

The positive economic impact will occur because a phased compliance plan should normally enable an owner or operator to remain in compliance with subchapter 19. As a result, the owner or operator will not incur penalties for violations of subchapter 19.

The Department expects that positive impact to outweigh the cost of preparing the phased compliance plan, which should be minor. In addition, though the owner or operator will incur costs to implement interim NO_x control measures, that cost should be lower than the cost of meeting the more stringent NO_x emission limits that would otherwise be applicable.

MEG Alerts

Under the proposed new rule at N.J.A.C. 7:27-19.24, an electric generating unit operating at emergency capacity during a MEG alert is eligible for an exemption from the NO_x emission limits that would otherwise apply. In proposing the MEG alert exemption, the Department is recognizing that electric generating units operating above their normal capacities during a MEG alert may often exceed their NO_x emission limits. The Department expects these provisions to have a positive net economic impact, as discussed below.

First, under the MEG alert exemption an electric generating utility will normally be able to remain in compliance with subchapter 19 during a MEG alert. As a result, a utility that exceeds its NO_x emission limits in its efforts to provide uninterrupted electric service during a MEG alert will not incur penalties for violations of subchapter 19.

Second, with the MEG alert exemption in place, the goal of compliance with subchapter 19 will no longer compete with the goal of meeting peak demand for electricity. Subchapter 19 therefore will not encourage voltage reductions or interruptions in electric service that could have an adverse economic impact upon the customers of electric generating utilities.

Though the Department expects the net economic impact of N.J.A.C. 7:27-19.24 to be positive, electric generating utilities will incur costs in complying with this provision. Specifically, the utilities will be required to compensate for the excess NO_x emissions emitted during MEG alerts.

If a utility generates the compensating emission reductions by temporarily reducing its own NO_x emissions below the limits required under applicable laws, regulations, permits or other standards, the cost will depend upon the nature of the combustion source from which the emission reductions are drawn, and the control measures employed to produce those reductions. If and when a system is established under

which a utility can purchase emission reduction credits, and the utility elects to compensate for excess NO_x emissions by purchasing credits, the cost of compliance will depend upon market forces at the time of the purchase.

The Department does not expect the reporting requirements of N.J.A.C. 7:27-19.24 to impose significant costs upon utilities.

Emergency Use of Fuel Oil

N.J.A.C. 7:27-19.24 addresses a situation in which a combustion source that relies upon natural gas as its primary fuel, or seasonally combusts natural gas, must temporarily combust another fuel when the supply of natural gas is disrupted. The source may not be able to meet the NO_x emission limits that apply to sources using the backup fuel. Accordingly, during the time that the source is combusting the backup fuel, it is eligible for an exemption from the NO_x emission limits.

The Department expects this exemption will have a positive economic impact upon the owners or operators of combustion sources eligible for the exemption. The exempton will allow these owners and operators to remain in compliance with subchapter 19 during disruptions in the supply of natural gas, so that they will not incur penalties for violations.

Other Amendments

Exemptions. Under N.J.A.C. 7:27-19.2(f) in the existing rules, the owner or operator of a facility may apply for an exemption from subchapter 19. A facility is not eligible for the exemption unless its daily potential to emit NO_x on any day from May 15 through September 15 is less than 137 pounds per day. The proposed amendments revise this exemption by changing May 15 to May 1. The Department does not expect this change to have any economic impact; any facility that is exempt under the current rules should continue to be exempt under the rules as amended.

Indirect heat exchangers. The proposed amendments define "indirect heat exchanger" and establish NO_x emission limits for this type of source. The Department expects this change to have a positive economic impact upon the owners and operators of such sources.

Under the existing rules, the owner or operator of any indirect heat exchanger other than a boiler would be required to obtain the Department's approval of a facility-specific NO_x control plan for the heat exchanger. In light of the similarity between boilers and other indirect heat exchangers, the Department expects that the facility-specific process would have resulted in the same emission limits that will be imposed under the proposed amendments to N.J.A.C. 7:27-19.7. Accordingly, the Department expects that the proposed amendments will not change the cost of complying with the NO_x emission limits; however, the proposed amendments will eliminate the cost of obtaining approval of a facility-specific NO_x control plan.

According to the EPA document entitled "Alternative Control Techniques Document—NO_x Emissions from Process Heaters," the owner or operator of a natural gas-fired process heater will incur costs ranging from approximately $1,200 to $2,400 per ton of NO_x emissions removed. The owner or operator of an oil-fired process heater (maximum gross heat input rate greater than 50 MMBTU/hr) will incur costs ranging from approximately $500.00 to $2,300 per ton of NO_x emissions removed. These costs are associated with the use of low-NO_x burners, expected to be the most commonly used method of NO_x control for these sources. The New Jersey Petroleum Council has indicated for process heaters combusting refinery fuel gas and using low-NO_x burners, it expects the approximate cost of NO_x emission control to be $1,000 to $4,000 per ton of NO_x emissions removed.

Environmental Impact

The Department expects the proposed amendments and new rules to have no adverse environmental impact. The environmental impact of each major provision of the proposed amendments and new rules is discussed below.

Seasonal Fuel Switching. The proposed new rule at N.J.A.C. 7:27-19.20 allows all combustion sources subject to subchapter 19 to attain compliance by using cleaner fuels during the ozone season. If a source uses seasonal fuel switching to comply with subchapter 19, the overall environmental impact is likely to be positive.

EPA has provided guidance stating that fuel switching serves the primary purpose of the CAAA NO_x RACT requirements: reducing ozone effects in areas of high ozone concentrations. Fuel switching provides greater NO_x emission reductions during the ozone season, which EPA states is much more effective than spreading lesser emission reductions evenly over the entire year. When the cleaner fuel is natural gas and it is used in place of coal, there can also be substantial reductions in summertime emissions of sulfur dioxide, carbon dioxide, PM-10 (particles with an aerodynamic diameter no greater than a nominal 10 micrometers), and associated toxic emissions such as mercury. Reductions in the emissions of these pollutants may be especially effective in reducing regional haze and sulfate-related PM-10, which tend to peak in summer.

Outside the ozone season, seasonal fuel switching will allow the source to emit NO_x at a higher rate. EPA has therefore noted the possibility that, for certain ecosystems, reductions in nitrogen deposition that occur only during the summer could be less effective than uniform year-round reductions in reducing acid deposition and nutrient impacts. This possibility would imply that some negative environmental impact during the winter could be associated with fuel switching. However, EPA has stated that it is not possible to fully determine whether this impact would occur, or to quantify it. In contrast, the ozone-related benefits and other potential benefits of fuel switching discussed above are known and quantifiable. However, the Department notes that under the proposed new rules, the emission limit outside the ozone season is the emission limit that would apply to the use of the primary fuel if a fuel switching plan were not in place; as a result, the use of fuel switching will not result in higher emissions during this period.

As discussed above in the Summary, allowing compliance through seasonal fuel switching also removes a disincentive to the use of cleaner fuels. As a result, the Department expects the use of cleaner fuels to be more widespread than it would be under the existing rules.

The precise nature of the environmental impact will depend upon the number of sources that elect to comply through seasonal fuel switching, the size of those sources, their NO_x emissions when other fuels are combusted, and the extent to which their NO_x emissions would be reduced under the existing rules.

For all of the reasons discussed above, the Department expects that seasonal fuel switching will have a positive environmental impact.

Repowering. Under the proposed new rule at N.J.A.C. 7:27-19.21, a combustion source that is to be repowered before May 1, 1999 may not be subject to the NO_x emission limits in the existing rules; instead, the source will be required to comply with certain less stringent requirements until it is repowered, it must incorporate advances in the art of air pollution control at the time it is repowered, and it must combust fuel more efficiently after it is repowered.

The increased fuel efficiency and use of state-of-the-art air pollution control technology can potentially reduce NO_x emissions from a repowered source by more than 90 percent in most cases. This compares very favorably with the 30 percent to 50 percent reduction expected to be achieved with RACT measures; it is also a greater reduction than is anticipated to be required as part of the Phase II Ozone Transport Commission NO_x reductions that are scheduled to be implemented in 1999. Therefore, encouraging repowering promotes emission reductions required to attain the ozone NAAQS.

Due to the nature of the repowering incentive, the positive environmental impact with respect to each repowered source will not occur until the source is repowered. However, there will not be a negative impact during the interim period between May 1995 and the repowering date. Under the existing rules, the upcoming repowering of a source could make it economically unfeasible to install the control technology needed to attain compliance with the applicable NO_x emission limit. As a result, the owner or operator of the source may have been eligible for a less stringent alternative NO_x emission limit under the existing rules at N.J.A.C. 7:27-19.13. The criteria for establishing an interim NO_x emission limit under the proposed new repowering rules are very similar to the criteria in the existing rules at N.J.A.C. 7:27-19.13. Accordingly, it is reasonable to expect that the interim limits would be the same under the proposed new rules or the existing rules, and would result in NO_x emission reductions during the interim period.

For these reasons, the Department expects the repowering incentive to have a long-term positive environmental impact.

Innovative control technology. Under the proposed new rule at N.J.A.C. 7:27-19.22, a combustion source that will employ innovative control technology before May 1, 1999 may not be subject to the NO_x emission limits in the existing rules; instead, the source will be required to comply with certain less stringent requirements until the innovative control measures are implemented. The use of innovative control technology can potentially provide greater reductions in NO_x emissions than are expected to be achieved with RACT measures.

Due to the nature of the incentive for innovative control technology, the positive environmental impact in any given case will not occur until the innovative measures are implemented. During the interim period, the positive environmental impact will be less than there otherwise would have been under subchapter 19; the extent of the difference depends upon the nature of the interim control measures required, and their efficacy in reducing NO_x emissions. However, the Department believes that the additional emissions reductions that result from the innovative control technology will more than balance the lower emission reductions during the interim period. In addition, the Department believes that the proposed new rules may help to spur the development and wider use of innovative control technology, resulting in wider positive environmental impacts.

Phased compliance—impracticability of compliance by May 31, 1995. The proposed new rule at N.J.A.C. 7:27-19.22 allows phased-in compliance for sources that cannot practicably meet the NO_x emission limits in subchapter 19 by May 31, 1995. The Department expects that this provision will have no significant environmental impact. Since exceedances of the NO_x limits from these sources could not practicably be prevented, they presumably would occur whether or not the source was deemed to be in compliance with subchapter 19. Accordingly, the Department does not expect that more exceedances (or more severe exceedances) would occur under the proposed new rules than would occur if subchapter 19 did not provide for phased-in compliance.

MEG Alerts. The proposed new rule at N.J.A.C. 7:27-19.24 provides that when an electric generating utility operates a source at emergency capacity during a MEG alert, that source is exempt from the emissions limits that would otherwise be applicable under subchapter 19. The excess NO_x emissions that will occur during a MEG alert will have a negative environmental impact, especially because the days on which MEG alerts occur often tend to be days on which ozone concentrations are already high. However, the Department expects this negative environmental impact to be offset by the compensating emission reductions that electric generating utilities will be required to provide at other times. In addition, MEG alerts tend to occur infrequently and to have a brief duration.

The extent of the environmental impact depends upon the following factors:

- The frequency with which MEG alerts occur, and their duration. PSE&G noted that in the three years preceding its comment, it has responded to MEG alerts for a total of only 16.2 hours;
- The extent of each MEG alert, including the amount of additional electricity that must be generated and the number and type of electric generating units that are operated at emergency capacity;
- The duration of each MEG alert; and
- The timing of each MEG alert. MEG alerts occur most frequently during the hottest periods of the summer, when ozone levels are likely to be elevated. Less frequently, MEG alerts occur during periods of bitterly cold weather during the winter, when exceedances of the ozone NAAQS are not likely to occur. In addition, MEG alerts on hot but overcast days are less likely to cause or contribute to an exceedance of the NAAQS because ozone forms in the presence of sunlight.

Emergency use of fuel oil. When supplies of natural gas are curtailed and combustion sources switch to liquid fuel as a temporary backup, the proposed new rule at N.J.A.C. 7:27-19.24 exempts those combustion sources from the NO_x emission limits that would otherwise apply. The Department expects this provision to have a small negative environmental impact. However, since natural gas curtailments occur most commonly during the winter, this provision is unlikely to result in increased ozone levels.

The extent of the environmental impact in any given year will depend upon the following factors:

- The frequency, extent, timing and duration of disruptions in the supply of natural gas; and
- For each source that must temporarily use liquid fuel as a backup to natural gas, the extent to which that NO_x emissions from the source will increase.

Regulatory Flexibility Analysis

Subchapter 19 applies to several classes of businesses. The classes of businesses expressly subject to subchapter 19 include electric generating utilities, asphalt manufacturers and glass manufacturers. In addition, Subchapter 19 regulates certain types of combustion sources (such as non-utility boilers, stationary internal combustion engines and other major NO_x facilities) that are not limited in their use to particular types of businesses. The Department cannot estimate the number of small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., that own or operate such combustion sources.

The proposed amendments and new rules primarily do not impose new compliance requirements upon the owners and operators of combustion sources regulated under subchapter 19. Instead, most of the proposed amendments and new rules either establish alternative means of complying with subchapter 19, or make it possible for owners and operators to avoid violating subchapter 19 and risking enforcement action and penalties in circumstances where compliance is impracticable.

However, there are some compliance requirements associated with the provisions for seasonal fuel switching under N.J.A.C. 7:27-19.20 and the provisions for phased compliance under N.J.A.C. 7:27-19.21, 19.22 and 19.23. An owner or operator seeking authorization to use one of these methods of compliance must complete an application and submit it to the Department. The Department expects that an owner or operator applying for approval of a repowering plan under N.J.A.C. 7:27-19.21 or an innovative control technology plan under N.J.A.C. 7:27-19.23 will need the professional services of an environmental engineer knowledgeable about air pollution control. Those professional services will be helpful in evaluating possible NO_x control measures and in implementing the repowering or innovative control technology. However, the Department expects that an owner or operator applying for approval of a seasonal fuel switching plan under N.J.A.C. 7:27-19.20 or a phased compliance plan under N.J.A.C. 7:27-19.22 will be able to prepare the application and implement the plan without these professional services.

Neither fuel switching under N.J.A.C. 7:27-19.20 or phased compliance under N.J.A.C. 7:27-19.22 should require the expenditure of initial capital costs; annual compliance costs will vary depending upon several factors, discussed in the economic impact statement above. An owner or operator who complies with subchapter 19 through repowering or innovative control technology will incur initial capital costs to repower or to implement the innovative control technology. In addition, such an owner or operator may incur initial capital costs to implement interim NO_x control measures, though those costs should be less than the capital costs involved in complying with the existing rules. As discussed in the economic impact statement above, these capital costs and the annual compliance costs will vary depending on several factors.

In proposing the requirements for fuel switching under N.J.A.C. 7:27-19.20 and phased compliance under N.J.A.C. 7:27-19.21, 19.22 and 19.23, the Department has attempted to minimize the adverse economic impacts of subchapter 19 on the regulated community in general; however, the requirements of the CAAA as interpreted by EPA do not provide the Department with the discretion to minimize these impacts further for small businesses in particular.

There are some recordkeeping and reporting requirements associated with the proposed amendments and new rules as described in the Summary. These requirements are necessary to ensure that the added flexibility provided by the proposed amendments and new rules does not impair the Department's ability to monitor compliance with subchapter 19 and its ability to establish the State's compliance with the requirements of the CAAA. In addition, the Department does not expect that small businesses complying with these requirements will need to obtain professional services or incur significant costs beyond those already necessary to comply with subchapter 19. Accordingly, the Department has not proposed reduced recordkeeping or reporting requirements for small businesses, or exempted them from those requirements.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

7:27-19.1 Definitions

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

...

"Base year" means calendar year 1990 or other calendar year determined pursuant to N.J.A.C. 7:27-19.20(d)1, in connection with a plan for seasonal fuel switching.

...

"Cleaner fuel" means a fuel other than a combustion source's primary fuel, the combustion of which results in a rate of NO_x emissions that is less than the rate of NO_x emissions when the primary fuel is combusted, all other circumstances being equal.

...

"Criteria pollutant" means any air contaminant for which a NAAQS has been promulgated under 40 CFR 50 or for which a New Jersey Ambient Air Quality Standard has been promulgated in N.J.A.C. 7:27-13.

...

"Duct burner" means an item of equipment used with a combined cycle gas turbine or a stationary internal combustion engine to increase the steam generating capacity of heat recovery steam generators. A duct burner consists of pipes and small burners that are placed in the exhaust duct upstream of the heat recovery steam generator; the duct burner allows firing of additional fuel to increase the exhaust heat energy. A duct burner is a type of indirect heat exchanger.

"Electric generating unit" means a combustion source owned or operated by an electric generating utility and used for generating electricity for commercial sale.

...

"Emergency capacity" means the generation of electricity by an electric generating unit at a rate in excess of the unit's maximum normal power output rating. This maximum normal power output rating shall be that agreed upon by PJM and the owner or operator of the unit, and published by the owner or operator.

...

"Indirect heat exchanger" means equipment in which heat from the combustion of fuel is transferred by conduction through a heat-conducting material to a substance being heated, so that the latter is not contacted by, and adds nothing to, the products of combustion. Examples of indirect heat exchangers include boilers, duct burners and process heaters.

"Innovative control technology" means a NO_x control measure that has a substantial likelihood of achieving lower continuous levels of NO_x emissions than are required under this subchapter, but has not been adequately demonstrated and is not available to be implemented before May 31, 1995. An item of equipment or control apparatus, a change in a process, or a pollution prevention strategy may qualify as an innovative control technology.

"Interim period" means the period of time beginning on May 31, 1995, and ending when phased compliance under N.J.A.C. 7:27-19.21, 19.22 or 19.23 (as applicable) is to be completed.

1. For purposes of phased compliance for repowering pursuant to N.J.A.C. 7:27-19.21, the interim period ends on the date when repowering of a combustion source is to be completed.

2. For purposes of phased compliance for reasons of practicability pursuant to N.J.A.C. 7:27-19.22, the interim period ends on the date when a combustion source is to attain full compliance with this subchapter.

3. For purposes of phased compliance for innovative control technology pursuant to N.J.A.C. 7:27-19.23, the interim period ends on the date when the innovative control technology is to be fully implemented.

...

"Lb/MMBTU" means pounds per million British Thermal Units.

...

"Load dispatcher" means the PJM employee or agent responsible for determining that an MEG alert is the only feasible means of preventing or mitigating either a voltage reduction or an interruption in electric service or both.

...

"MEG alert" means a period in which an electric generating utility operates one or more electric generating units at emergency capacity at the direction of the load dispatcher, in order to prevent or mitigate voltage reductions or interruptions in electric service, or both. A MEG alert begins and ends as follows:

1. An alert begins when the electric generating utility begins to operate one or more electric generating units at emergency capacity after receiving notice from the load dispatcher, directing the utility to do so; and

2. An alert ends when the electric generating utility ceases operating its electric generating units at emergency capacity.

"MMBTU" means million British Thermal Units.

...

"Peak daily heat input rate," for a combustion source that has no operating history, means the maximum gross heat input rate of the source. For a combustion source that has an operating history, "peak daily heat input rate" means the average of the daily heat inputs to a combustion source on the five days on which the heat input was highest, over the following period:

1. For a combustion source that has been operating for at least five years, the five years preceding the date on which the owner or operator applied to the Department for approval of an emissions averaging plan, pursuant to N.J.A.C. 7:27-19.6; and

2. For a combustion source that has been operating for less than five years, the entire period during which the combustion source has been operating.

"Pennsylvania-New Jersey-Maryland Interconnection" or "PJM" means the combination of electric generating utilities, linked physically and through contractual arrangements, for coordinated electricity planning and operation in an area that as of 1994 includes New Jersey, Maryland, Pennsylvania, Virginia, Delaware and the District of Columbia.

...

"Primary fuel" means the fuel that provided the greatest heat input (expressed in BTU) to a combustion source in the base year.

"Process heater" means an item of equipment in which heat from fuel combustion is transferred to fluids contained in tubes without coming into contact with the fluid. A process heater is a type of indirect heat exchanger.

...

"Refinery fuel gas" means gaseous fuel derived from the refining process and used as a fuel at the refinery where it was produced.

"Refining process" means the combination of physical and chemical operations including, but not limited to, distillation, cracking, and reformulation, performed on crude oil (or derivatives of crude oil) in order to produce petroleum products.

...

"Repowering" means the series of actions described in 1 and 2 below by an owner or operator:

1. The [replacement] permanent ceasing of the operations of the [stream] steam generator in a steam generating unit, the gas turbine in a simple-cycle or combined-cycle gas turbine, or any other combustion source; and

2. The installation in the State of a new combustion source that:

i. Has a maximum gross heat output rate that is at least 50 percent of the maximum gross heat output rate of the combustion source that is shut down under 1 above, or has a power output rate that is at least 50 percent of the power output rate of the combustion source that is shut down, and

ii. Incorporates technology capable of controlling multiple combustion emissions simultaneously with improved fuel efficiency and with significantly greater waste reduction relative to the performance of technology in widespread commercial use as of November 15, 1990.

...

"Selective noncatalytic reduction" or "SNCR" means a noncombustion technology that reduces NO_x emissions without a catalyst by injecting a reducing agent (such as ammonia, urea or cyanuric acid) into the flue gas, downstream of the combustion zone; the injection of the reducing agent converts NO_x to molecular nitrogen, water, and (if the reducing agent is urea or cyanuric acid) carbon dioxide (CO_2).

...

7:27-19.2 Purpose, scope and applicability

(a) (No change.)

(b) The following types of equipment and source operations are subject to the provisions of this subchapter:

1. (No change.)

2. Any non-utility boiler or other indirect heat exchanger which has a maximum gross heat input rate of at least 20 million BTUs per hour;

3.-8. (No change.)

(c)-(e) (No change.)

(f) The owner or operator of a facility containing any equipment or source operation listed in (b) above may apply to the Department for an exemption from this subchapter. The procedure for obtaining the Department's approval of such an exemption is set forth in N.J.A.C. 7:27-19.14. The Department shall approve the exemption only if the facility satisfies the requirements of (f)1 and 2 below:

1. (No change.)

2. The facility's potential to emit NO_x on any calendar day from May [15] **1** to September 15 is less than 137 pounds per day.

7:27-19.3 General provisions

(a)-(e) (No change)

[(f) The requirement for an owner or operator set forth in N.J.A.C. 7:27-19.3(d) above may be waived by the Department if:

1. The source operation which will be permanently shut down prior to May 31, 1995; and

2. The owner or operator submits a request for a waiver to the Department by April 23, 1994. Such request shall include:

i. A statement of the date (prior to May 31, 1995) the source operation will be permanently shut down; and

ii. Certification in accordance with N.J.A.C. 7:27-8.24.]

(f) In lieu of complying with the applicable emission limits set forth at N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, the owner or operator of a utility boiler, stationary gas turbine, non- utility boiler, indirect-fired heat exchanger, stationary internal combustion engine, asphalt plant or glass manufacturing furnace may comply with one of the following, or with a combination of (f)1 and 3 below:

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

(g) (No change)

(h) A person required to provide notice to the Department under this subchapter shall send the notice to the applicable address listed below:

1. If the notice concerns a combustion source located in Burlington County, Mercer County, Middlesex County, Monmouth County or Ocean County, the person shall send the notice to:

Central Regional Office
Horizon Center
CN 407
Robbinsville, NJ 08625-0407

2. If the notice concerns a combustion source located in Bergen County, Essex County, Hudson County or Union County, the person shall send the notice to:

Metro Regional Office
2 Babcock Place
West Orange, NJ 07052-5504

3. If the notice concerns a combustion source located in Hunterdon County, Morris County, Passaic County, Somerset County, Sussex County or Warren County, the person shall send the notice to:

Northern Regional Office
1259 Route 46 East
Parsippany, NJ 07054-4191

4. If notice concerns a combustion source located in Atlantic County, Camden County, Cape May County, Cumberland County, Gloucester County or Salem County, the person shall send the notice to:

Southern Regional Office
20 East Clementon Road
3rd Floor, Suite 302
Gibbsboro, NJ 08026-1175

5. If the notice concerns an averaging plan, the person shall determine the county in which the averaging unit with the highest potential to emit NO_x is located, and send the notice to the address applicable to that county under (h)1 through 4 above.

7:27-19.4 Utility boilers

(a) The owner or operator of a utility boiler shall cause it to emit NO_x at a rate no greater than the applicable maximum allowable NO_x emission rate specified in Table 1 below, unless the owner or operator of the utility boiler is **complying with one of the following, or with a combination of (a)1 and 3 below:**

[1. Complying with (b) or (c) below in lieu of complying with the emission limits set forth in Table 1 below, under the Department's written approval obtained pursuant to N.J.A.C. 7:27-19.14; or

2. Complying with an averaging plan submitted under N.J.A.C. 7:27-19.6 and approved by the Department in writing pursuant to N.J.A.C. 7:27-19.14.]

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the boiler, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the boiler, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the boiler, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

TABLE 1

Maximum Allowable NO_x Emission Rates for Utility Boilers (pounds per million BTU)

	Firing Method		
Fuel/Boiler Type	Tangential	Face	Cyclone
Coal—Wet Bottom	1.0[1]	1.0[1]	0.60
Coal—Dry Bottom	0.38	0.45	0.55
Oil and/or Gas	0.20	0.28	0.43
Gas Only	0.20	0.20	0.43

[1]Except as provided in (b) below.

[(b) In lieu of complying with the emission limits set forth in (a) above, the owner or operator of a coal-fired wet-bottom utility boiler which uses the tangential or face firing method may comply with the requirements of this subsection, which provides for seasonal combustion of natural gas. This shall not include a utility boiler which used natural gas as its primary fuel in 1990 or which currently uses natural gas as its primary fuel. The owner or operator electing to comply with this subsection shall satisfy all of the following requirements:

1. Before July 1, 1994, submit to the Department an application for approval of seasonal natural gas combustion, pursuant to N.J.A.C. 7:27-19.4(a), (b) and (c);

2. Before May 1, 1995, obtain the Department's written approval of the application pursuant to N.J.A.C. 7:27-19.14, and maintain that approval in effect;

3. Comply with all conditions of the Department's written approval;

4. Beginning in calendar year 1995, comply with the following requirements:

i. From May 1 to September 15 of each year, combust natural gas in the utility boiler; and

ii. Operate the utility boiler so that it emits NO_x at an average rate for each calendar day no greater than one pound of NO_x per million BTUs; and

5. For every calendar year beginning in 1995, operate the utility boiler so that the average NO_x emission rate over the entire calendar year does not exceed 1.5 pounds of NO_x per million BTUs.

(c) In lieu of complying with the emission limits set forth in (a) above, the owner or operator of a utility boiler which is to be

repowered before May 15, 1999 may comply with the requirements of this subsection. The owner or operator electing to comply with this subsection shall satisfy all of the following requirements:

1. Before May 1 of each calendar year beginning with 1995, adjust the combustion process in accordance with the general procedures set forth at N.J.A.C. 7:27-19.16;

2. Before January 1, 1995, enter into a Federally enforceable agreement with the Department which prohibits the continued operation of the utility boiler after April 30, 1999, unless its repowering is completed before that date and it meets the emission limitations specified in Table 2 below thereafter;

3. Before July 1, 1994, submit to the Department an application for approval of compliance under this subsection, pursuant to N.J.A.C. 7:27-19.14(a), (b) and (c), and include in the application specific procedures and schedules for adjustment of the boiler's combustion process in addition to the general procedures set forth in N.J.A.C. 7:27-19.16, and a proposed schedule of milestones for obtaining permits and purchasing equipment for the repowering of the boiler;

4. Obtain the Department's written approval of the application pursuant to N.J.A.C. 7:27-19.14, including, without limitation, approval of the combustion adjustment procedures and schedules based upon a determination that such procedures and schedules will minimize total emissions of NO_x, VOC and CO to the extent practicable using procedures and schedules which are technologically and economically feasible;

5. Maintain the Department's approval in effect; and

6. Comply with all conditions of the Department's written approval, and meet all milestones in that approval (such as for permit applications and permit approvals).

TABLE 2
Maximum Allowable NO_x Emission Rates
for Utility Boilers
Which Have Been Repowered
(pounds per million BTU)

	Firing Method		
Fuel/Boiler Type	Tangential	Face	Cyclone
Coal—Wet Bottom	0.2	0.2	0.2
Coal—Dry Bottom	0.2	0.2	**
Oil and/or Gas	0.1	0.1	0.1
Gas Only	0.1	0.1	**]

[(d)](**b**) (No change in text.)

7:27-19.5 Stationary gas turbines

(a) No stationary simple cycle gas turbine which has a maximum gross heat input rate of at least 30 million BTUs per hour may emit NO_x at a rate greater than the applicable maximum allowable NO_x emission rate specified in Table [3]**2** below, unless the owner or operator is complying with [an averaging plan including that turbine which has been submitted under N.J.A.C. 7:27-19.6 and approved by the Department in writing pursuant to N.J.A.C. 7:27-19.14.] **one of the following, or with a combination of (a)1 and 3 below:**

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

TABLE [3]**2**
Maximum Allowable NO_x Emission Rate for
Simple Cycle Gas Turbines
(Pounds per million BTU)

Fuel Used	Emission Limit
Oil	0.4
Gas	0.2

(b) No combined cycle gas turbine or regenerative cycle gas turbine which has a maximum gross heat input rate of at least 30 million BTUs per hour may emit NO_x at a rate greater than the applicable maximum allowable NO_x emission rate specified in Table [4]**3** below, unless the owner or operator is complying with [an averaging plan including that turbine which has been submitted under N.J.A.C. 7:27-19.6 and approved by the Department in writing pursuant to N.J.A.C. 7:27-19.14.] **one of the following, or with a combination of (b)1 and 3 below:**

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the turbine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

TABLE [4]**3**
Maximum Allowable NO_x Emission Rate for
Combined Cycle or Regenerative Cycle Gas Turbines
(Pounds per million BTU)

Fuel Used	Emission Limit
Oil	0.35
Gas	0.15

(c) (No change.)

7:27-19.6 Emissions averaging

(a) The Department may authorize an owner or operator to comply with an averaging plan approved by the Department pursuant to this section and **N.J.A.C. 7:27-19.14.** An owner or operator in compliance with such an approved averaging plan is not required to **have each averaging unit** comply with any emission limit set forth in this subchapter which would be applicable in the absence of an approved averaging plan.

(b) [The] **An** owner or operator of two or more source operations or items of equipment may request that the Department authorize an averaging plan for two or more averaging units designated by the owner or operator. The owner or operator seeking authorization for averaging shall submit a written [request] **application** to the Department [at the address set forth in (k) below] **in accordance with N.J.A.C. 7:27-19.14(a), (b) and (c).** The owner or operator shall include the following information in the [request] **application**:

1.-4. (No change.)

5. The peak daily heat input rate, [calculated by averaging the heat input to the unit,] expressed in MMBTU[, from the five highest days in the last five years];

6. A demonstration that in operating at their peak daily heat input rates, all of the averaging units together would satisfy the following equation:

$$TPEE \leq TPAE$$

where:

i. (No change.)

ii. TPAE means total peak allowable emissions, and is equal to the sum of the total peak allowable emissions for each averaging unit. The peak allowable NO_x emission limit set forth in N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9, [or] 19.10 **or 19.20** for that averaging unit, multiplied by the peak daily heat input rate listed in (b)5 above for that averaging unit. **For an averaging unit that is included in**

a seasonal fuel switching plan under N.J.A.C. 7:27-19.20, the peak allowable NO_x emission limit from May 1 through September 15 is the limit established under N.J.A.C. 7:27-19.20(d), and the peak allowable NO_x emission limit from September 16 through April 30 is the limit established under N.J.A.C. 7:27-19.20(g)4;

7.-9. (No change.)

(c) The Department shall approve an averaging plan only if the following requirements are satisfied:

1. (No change.)

2. The request for authorization satisfies all requirements of (b) above; **and**

3. The owner and operator of the averaging units to be included in the designated set enter into a Federally enforceable agreement with the Department (such as the inclusion of conditions in the applicable permits [and/or] **or** operating certificates**, or both**), requiring any averaging unit for which the NO_x emission rate specified under (b)4 above is less than the applicable maximum allowable NO_x emission rate specified at N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9, [or] 19.10 **or 19.20** to continue to emit NO_x at [the] **a** rate **no greater than that** specified under (b)4 above[; and].

[4. Emissions from any averaging unit exceeding the applicable NO_x emission limit under N.J.A.C. 7:27-19.4 or 19.5 will not cause the concentration of NO_x in the ambient air to exceed the applicable significant air quality impact level set forth in Table 1 at N.J.A.C. 7:27-18.4 or any other environmental impact inconsistent with the purposes of this chapter, the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., or the Clean Air Act, 42 U.S.C. 7401 et seq.]

(d) The owner or operator of the designated set shall operate each unit in the designated set in compliance with the following:

1. (No change.)

2. The sum of the actual NO_x emissions from all averaging units in the designated set, averaged over the appropriate time period specified in (f) below, shall not exceed the sum of the allowable NO_x emissions for all averaging units in the designated set. The allowable NO_x emissions for each averaging unit is calculated according to the following formula:

$$\text{Allowable } NO_x \text{ emissions} = H \times AL$$

where:

i. (No change.)

ii. AL means the applicable NO_x emission limit set forth in N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9, [or] 19.10 **or 19.20** for that averaging unit, expressed in pounds of NO_x per million BTUs. **For an averaging unit that is included in a seasonal fuel switching plan under N.J.A.C. 7:27-19.20, the applicable NO_x emission limit from May 1 through September 15 is the limit established under N.J.A.C. 7:27-19.20(g)3, and the applicable NO_x emission limit from September 16 through April 30 is the limit established under N.J.A.C. 7:27-19.20(g)4.**

(e) (No change.)

(f) The owner or operator shall demonstrate compliance with this section as follows:

1. The owner or operator shall determine whether the operations of the designated set **and of each averaging unit** comply with this section for each calendar day during the period beginning May [15] **1** and ending September 15 of each year. The owner or operator shall base the calculations required under (d)1 and 2 above upon the heat input and NO_x emissions for each averaging unit over the entire calendar day. The owner or operator shall perform the calculations and make a record of them within three working days after the date which is the subject of the calculation; and

2. The owner or operator shall determine whether the operations of the designated set **and of each averaging unit** comply with this section for the 30-day period [beginning] **ending on** September 16 of each year, and the 30-day period [beginning] **ending** on each subsequent day through [May 14] **April 30** of the following year. The owner or operator shall base the calculations required under (d)1 and 2 above upon the heat input and NO_x emissions for each averaging calculations and make a record of them by the 15th day of each month, for all 30-day periods ending in the preceding month.

(g) The owner or operator of a designated set shall maintain the records listed below for five years from the date on which each record was made. The owner or operator shall maintain such records in a permanently bound log book, in a format [approved in writing by the Department] **that enables the Department to readily determine whether the designated set and each averaging unit are in compliance**. The owner or operator shall maintain the following records:

1.-9. (No change.)

(h) (No change.)

(i) If the emissions from the designated set or from any averaging unit do not comply with (d) above for any time period described in (f) above, the owner or operator of the designated set shall deliver (as opposed to send) written notice of the non-compliance to the Department within two working days after the date on which the owner or operator was required to calculate compliance under (f) above. The owner or operator shall provide the notice in writing to the Regional Enforcement Officer, at the address specified [in (1) below] **at N.J.A.C. 7:27-19.3(h)** for the county in which the averaging unit with the highest NO_x emission rate is located. The owner or operator shall include the following information in the notification:

1.-5. (No change.)

(j) An [electric generating utility operating a utility boiler or stationary gas turbine] **owner or operator of an averaging unit** which cannot be operated due to sudden and reasonably unforeseeable circumstances beyond the [utility's] control **of the owner or operator**, and for which the NO_x emission rate specified under (b)4 above is less than the applicable maximum allowable NO_x emission rate under N.J.A.C. 7:27-19.4 [or], 19.5, **19.7, 19.8, or 19.10** shall take the following actions:

1.-3. (No change.)

[(k) A person submitting a request for authorization of an averaging plan shall send the request to the Department at the following address:

Chief, Bureau of Air Quality Engineering
Department of Environmental Protection and Energy
401 East State Street
CN 027
Trenton, New Jersey 08625-0027

(l) A person required to provide notice to the Department under (i) above shall send the notice to the applicable address listed in (l)1 through 4 below.

1. If the averaging unit with the highest NO_x emission limit is located in Burlington County, Mercer County, Middlesex County, Monmouth County or Ocean County:

Central Regional Office
Horizon Center
CN 407
Robbinsville, NJ 08625-0407

2. If the averaging unit with the highest NO_x emission limit is located in Bergen County, Essex County, Hudson County or Union County:

Metro Regional Office
2 Babcock Place
West Orange, NJ 07052-5504

3. If the averaging unit with the highest NO_x emission limit is located in Hunterdon County, Morris County, Passaic County, Somerset County, Sussex County or Warren County:

Northern Regional Office
1259 Route 46 East
Parsippany, NJ 07054-4191

4. If the averaging unit with the highest NO_x emission limit is located in Atlantic County, Camden County, Cape May County, Cumberland County, Gloucester County or Salem County:

Southern Regional Office
20 East Clementon Road
3rd Floor, Suite 302
Gibbsboro, NJ 08525-1175]

7:27-19.7 Non-utility boilers **and other indirect heat exchangers**

(a) Beginning in calendar year [1994] **1995**, the owner or operator of a non-utility boiler **or other indirect heat exchanger** with a maximum gross heat input rate of at least 20 million but less than 50 million BTUs per hour shall:

1. [annually] **Annually** adjust the combustion process in accordance with N.J.A.C. 7:27-19.16 before May 1 of each year; **or**

2. Cause the boiler or other indirect heat exchanger to emit NO_x at a rate no greater than the applicable maximum allowable NO_x emission rate specified in Table 4 below, and establish compliance with this requirement by continuous emissions monitoring pursuant to N.J.A.C. 7:27-19.15(a)1.

(b) Beginning on May 31, 1995, the owner or operator of a non-utility boiler **or other indirect heat exchanger** with a maximum gross heat input rate of at least 50 million but less than 100 million BTUs per hour shall cause the boiler **or other indirect heat exchanger** to emit NO_x at a rate no greater than the applicable maximum allowable NO_x emission rate specified in Table [5] **4** below, **and comply with the applicable requirements of (d) below.**

TABLE [5] **4**

Maximum Allowable NO_x Emission Rates for Non-utility Boilers **and other Indirect Heat Exchangers** Subject to N.J.A.C. 7:27-19.7(b) (pounds per million BTU)

	Firing Method		
Fuel/Boiler Type	Tangential	Face	Cyclone
Coal—Wet Bottom	1.0	1.0	0.55
Coal—Dry Bottom	0.38	0.43	0.55
#2 Fuel Oil	0.12[1]	0.12[1]	0.12[1]
Other Liquid Fuels	0.3[1]	0.3[1]	0.3[1]
Refinery fuel gas	**0.20**	**0.20**	**N/A**
Natural Gas	0.1	0.1	0.1

[[1]Except as provided for in (c) above.]

(c) Beginning on May 31, 1995, the owner or operator of a non-utility boiler **or other indirect heat exchanger** with a maximum gross heat input rate of at least 100 million BTUs per hour shall cause the boiler **or other indirect heat exchanger** to emit NO_x at a rate no greater than the applicable maximum allowable NO_x emission rate specified in Table [6] **5** below, **and comply with the applicable requirements of (d) below.**

TABLE [6] **5**

Maximum Allowable NO_x Emission Rates for Non-utility Boilers and **other Indirect Heat Exchangers** Subject to N.J.A.C. 7:26-19.7(c) (pounds per million BTU)

	Firing Method		
Fuel/Boiler Type	Tangential	Face	Cyclone
Coal—Wet Bottom	1.0	1.0	0.60
Coal—Dry Bottom	0.38	0.45	0.55
Oil and/or Gas	0.20	0.28	0.43
Refinery fuel gas	**0.20**	**0.20**	**N/A**
Gas Only	0.20	0.20	0.43

(d) [The] **In addition to complying with (c) above,** the owner or operator of any non-utility boiler **or other indirect heat exchanger** with a maximum gross heat input rate of at least 250 million BTUs per hour shall install a continuous emissions monitoring system in accordance with N.J.A.C. 7:27-19.18. **In addition to complying with (b) or (c) above, as applicable, the owner or operator of a non-utility boiler or other indirect heat exchanger with a maximum gross heat input rate of at least 50 million BTUs per hour but less than 250 million BTUs per hour shall either:**

1. Annually adjust the combustion process in accordance with N.J.A.C. 7:27-19.16, before May 1 of each year; or

2. Establish compliance with the applicable maximum allowable emission rate by continuous emissions monitoring pursuant to N.J.A.C. 7:27-19.15(a)1.

(e) In lieu of complying with a NO_x emission limit under (b) or (c) above, the owner or operator of a non-utility boiler or other indirect heat exchanger may comply with one of the following, or with a combination of (e)1 and 3 below:

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

7:27-19.8 Stationary internal combustion engines

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

(d) In lieu of complying with a NO_x emission limit under (a), (b) or (c) above, the owner or operator of a stationary internal combustion engine may comply with one of the following, or with a combination of (d)1 and 3 below:

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the engine, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the engine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the engine, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

7:27-19.9 Asphalt plants

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

(c) In lieu of complying with a NO_x emission limit under (a) above, the owner or operator of an asphalt plant may comply with one of the following, or with a combination of (c)1 and 3 below:

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the unit, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

7:27-19.10 Glass manufacturing furnaces

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

(f) In lieu of complying with a NO_x emission limit under (a), (b) or (c) above, the owner or operator of a glass manufacturing furnace may comply with one of the following, or with a combination of (f)1 and 3 below:

1. An emissions averaging plan approved by the Department pursuant to N.J.A.C. 7:27-19.6 and 19.14, which includes the combustion source in question as an averaging unit;

2. An alternative maximum allowable emission rate for the furnace, approved by the Department pursuant to N.J.A.C. 7:27-19.13;

3. A seasonal fuel switching plan for the furnace, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and 19.20; or

4. A plan for phased compliance for the furnace, approved by the Department pursuant to N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21, 19.22 or 19.23.

7:27-19.13 Facility-specific NO_x emissions limits

(a) This section establishes procedures and standards for the establishment of facility-specific NO_x emissions limits in the following circumstances:

1. If a major NO_x facility contains any source operation or item of equipment **of a category** not listed in N.J.A.C. 7:27-19.2(b) **(that is, any source operation or item of equipment other than a utility**

boiler, a non-utility boiler, a stationary gas turbine, a stationary internal combustion engine, a rotary dryer located at an asphalt plant, or a glass manufacturing furnace) which has the potential to emit more than 10 tons of NO_x per year, except as provided in (p) below; or

2. (No change.)

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

(g) Within six months after receiving a complete proposed NO_x control plan or request for an alternative maximum allowable emission rate, the Department shall approve, approve and modify, or disapprove the proposed plan or request and notify the owner or operator of the decision in writing. The Department shall approve the proposed plan or request only if it satisfies the following requirements:

1.-5. (No change.)

6. [Emissions at each proposed limit will not cause the concentration of NO_x in the ambient air to exceed the applicable significant air quality impact level set forth in Table 1 at N.J.A.C. 7:27-18.4 or any other environmental impact inconsistent with the purposes of this chapter, the Air Pollution Control Act, N.J.S.A. 26:2C-1 et seq., or the Clean Air Act, 42 U.S.C. 7401 et seq.] **Increases in the emissions of any criteria pollutant (as determined pursuant to N.J.A.C. 7:27-19.17 or 19.18, as applicable) do not cause or significantly contribute to a violation of a National Ambient Air Quality Standard, an exceedance of a Federal Prevention of Significant Deterioration increment, or any violation of the Clean Air Act, 42 U.S.C. 7401 et seq.**

(h)-(p) (No change.)

7:27-19.14 Procedures for obtaining approvals under this subchapter

(a) This section establishes the procedure for obtaining [the Department's approval of] any of the following **from the Department**:

1. (No change)

2. [Compliance with the requirements of N.J.A.C. 7:27-19.4(b) for utility boilers which will combust natural gas seasonally] **Approval of a fuel switching plan under N.J.A.C. 7:27-19.20, and authorization to operate under the plan;**

3. [Compliance with the requirements of N.J.A.C. 7:27-19.4(c) for utility boilers to be repowered] **Approval of a plan for phased compliance under N.J.A.C. 7:27-19.21, 19.22 or 19.23, and authorization to operate under the plan;**

4. [Compliance] **Approval of compliance** with the requirements of N.J.A.C. 7:27-19.5(c) for a stationary gas turbine; [or]

5. **Approval of an emissions averaging plan under N.J.A.C. 7:27-19.6, and authorization to operate under the plan; or**

[5. An]**6. Approval of an** alternative monitoring plan pursuant to N.J.A.C. 7:27-19.18(b).

(b) (No change)

(c) The person seeking the approval under (a) above shall include the following information in the application submitted under (b) above:

1. Any information required under N.J.A.C. 7:27-19.2(f), [19.4(b), 19.4(c),] 19.5(c) [or], **19.6(b)**, 19.18(c), **19.20 or 19.21**, as applicable;

2.-7. (No change)

(d) (No change)

(e) Within six months after receiving a complete application, the Department shall notify the applicant of its decision on the application. The Department shall grant its approval under this section only if:

1. [the] **The** applicant satisfies all eligibility requirements set forth in N.J.A.C. 7:27-[19.4(b), 19.4(c) or 19.5(c)], **19.5(c), 19.6(c), 19.20, or 19.21** as applicable[.]; **and**

2. Increases in the emissions of any criteria pollutant (as determined pursuant to N.J.A.C. 7:27-19.17 or 19.18, as applicable) do not cause or significantly contribute to a violation of a National Ambient Air Quality Standard as determined pursuant to N.J.A.C. 7:27-18, an exceedance of a Federal Prevention of Significant Deterioration increment if applicable, or any violation of the Clean Air Act, 42 U.S.C. 7401 et seq.

(f)-(j) (No change)

7:27-19.15 Procedures and deadlines for demonstrating compliance

(a) The owner or operator of equipment or a source operation subject to an emission limit under this subchapter shall demonstrate compliance with the emission limit [pursuant to (a)1 below if a continuous emissions monitoring system has been installed on the equipment or source operation, or pursuant to (a)2 below if no such system has been installed.] **as follows:**

1. If a continuous emissions monitoring system has been installed on the equipment or source operation, [compliance] **or if any other provision of this subchapter requires emissions from the equipment or source operation to be monitored by a continuous emissions monitoring system under N.J.A.C. 7:27-19.18, the owner or operator shall calculate the average NO_x emission rate using the data from such a system for the NO_x concentration in the flue gas and either the flue gas flow rate or the fuel flow rate. To calculate the emission rate using the NO_x concentration and fuel flow rate, the owner or operator shall use the conversion procedure set forth in the Acid Rain regulations at 40 CFR part 75, Appendix F, or an alternative procedure that the Department determines will yield the same result. Compliance** with the limit [is] **shall be** based upon the average of emissions:

i. Between May [15] **1** and September 15, over each calendar day; [or] **and**

ii. [At all other times, over each rolling 30 calendar day period.] **From September 16 through April 30 of the following year, over the 30-day period ending on each such day; or**

2. If no continuous emissions monitoring system has been **or is required to be** installed on the equipment or source operation, compliance with the limit [is] **shall be** based upon the average of three one-hour tests, each performed over a consecutive 60-minute period specified by the Department, and performed in compliance with N.J.A.C. 7:27-19.17.

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

7:27-19.19 Recordkeeping **and reporting**

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

(c) The recordkeeping requirements in (d) and (e) below apply to the owner or operator of any combustion source that is:

1. Included in a fuel switching plan approved under N.J.A.C. 7:27-19.14 and 19.20;

2. Included in a plan for phased compliance approved under N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.21 or 19.23; or

3. Temporarily combusting fuel oil or other liquid fuel in place of natural gas, pursuant to N.J.A.C. 7:27-19.25.

(d) For each combustion source listed in (c) above, the owner or operator shall record the following information for each day from May 1 through September 15, for the 30-day period ending on September 16, and for each 30-day period ending on each subsequent day through April 30 of the following year:

1. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

2. The day or 30-day period, as applicable, for which the record is being made;

3. The amount, type and higher heating value of each fuel consumed during each day from May 1 through September 15, during the 30-day period ending on September 16, and during each 30-day period ending on each subsequent day through April 30 of the following year;

4. The quantity of NO_x emitted during the day or 30-day period, as applicable, determined in accordance with N.J.A.C. 7:27-19.15(a) and expressed in pounds or tons; and

5. Any other information required to be maintained as a condition of an approval granted under N.J.A.C. 7:27-19.14 and N.J.A.C. 7:27-19.20, 19.21 or 19.23.

(e) The owner or operator of a combustion source listed in (c) above shall keep the records required under (d) above at the facility

in a permanently bound log book, in a format that enables the Department to readily determine whether the combustion source is in compliance.

(f) The reporting requirements in (g) through (i) below apply to the owner or operator of any combustion source that is:

1. Included in a fuel switching plan approved under N.J.A.C. 7:27-19.14 and 19.20;

2. To be repowered pursuant to a plan for phased compliance approved under N.J.A.C. 7:27-19.14 and 19.21; or

3. To be implementing innovative control technology pursuant to a plan for phased compliance approved under N.J.A.C. 7:27-19.14 and 19.23.

(g) The owner or operator of a combustion source listed in (f) above shall submit a report to the Department on October 30 of each year, concerning the period from May 1 through September 15. The owner or operator shall include in the report the following information concerning each combustion source listed in (f) above:

1. The records listed in (d) above;

2. A statement whether the combustion source complied with the applicable limit on daily NO_x emissions on each day; and

3. The basis for the statement in (g)2 above.

(h) On March 1 of each year, the owner or operator of a combustion source listed in (f) above shall submit to the Department an annual report for the preceding calendar year. The owner or operator need not include information which has already been submitted in the report under (g) above, but shall include the following information in the annual report for each combustion source listed in (f) above:

1. The records listed in (d) above;

2. A statement whether the combustion source complied with the applicable limit on NO_x emissions for each 30-day period ending on each day from January 1 through April 30, and for each 30-day period ending on each day from September 16 through December 31;

3. For each combustion source included in a fuel switching plan, a statement whether the combustion source complied with the applicable limit on annual NO_x emissions; and

4. The basis for the statements in (h)2 and 3 above.

(i) If the emissions from any combustion source listed in (f) above do not comply with the applicable limit on daily NO_x emissions for any day from May 1 through September 15, the owner or operator shall deliver (as opposed to send) written notice of the non-compliance to the Department within two working days after the date on which the owner or operator was required to determine whether the source was in compliance with the daily limit. The owner or operator shall provide the notice in writing at the applicable address specified at N.J.A.C. 7:27-19.3(h). The owner or operator shall include the following information in the notification:

1. The name of the owner or operator;

2. The name and telephone number of the individual responsible for recordkeeping and reporting;

3. All information required to be recorded under (d) above;

4. A statement of the reasons for the non-compliance, if known; and

5. Certification of the notification, in accordance with N.J.A.C. 7:27-8.24.

7:27-19.20 Fuel switching

(a) The owner or operator of a combustion source included in a plan for fuel switching is authorized to comply with the plan if the Department approves the plan pursuant to this section and N.J.A.C. 7:27-19.14. The owner or operator's compliance with the plan is in lieu of causing the combustion source to comply with the emission limit under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would otherwise apply to the combustion source.

(b) A combustion source may be included in a fuel switching plan only if it will be deriving from a cleaner fuel a greater percentage of its total heat input than it derived in the base year.

(c) An owner or operator seeking approval of a plan for fuel switching shall submit an application to the Department by (date that is 30 days after operative date of these amendments), in accordance with N.J.A.C. 7:27-19.14(a), (b) and (c). In addition to the information required under N.J.A.C. 7:27-19.14(c), the owner or operator shall include in the application the following information regarding each combustion source that is to combust a cleaner fuel seasonally:

1. Information sufficient to identify the combustion source, including a brief description, (for example, "dry-bottom coal-fired utility boiler" or "oil-fired simple-cycle gas turbine"), its location, its permit number, its company stack designation, any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the applicant;

2. The maximum gross heat input rate of the combustion source, expressed in million BTUs per hour;

3. The type of fuel or fuels combusted in the combustion source;

4. The maximum allowable NO_x emission rate for the combustion source, determined under (d) below, together with the calculations made to determine that rate;

5. The method to be used to measure the actual NO_x emission rate of each combustion source;

6. A statement that the owner or operator will operate each combustion source included in the plan in accordance with the requirements of (g) below;

7. The name and business telephone number of the individual responsible for recordkeeping and reporting required under N.J.A.C. 7:27-19.19; and

8. Any other information that the Department requests, which is reasonably necessary to enable it to determine whether the source operations and items of equipment subject to fuel switching will comply with the requirements of this section.

(d) The maximum daily and annual NO_x emission rate for a combustion source included in the fuel switching plan is determined as follows:

1. Establish the base year. The base year is calendar year 1990, unless the Department approves the use of calendar year 1991, 1992 or 1993 as the base year. The Department shall approve the use of 1991, 1992 or 1993 as the base year only if the owner or operator demonstrates that the alternative year is more representative of the normal operation of the combustion source;

2. For each fuel that the combustion source combusted during the base year (established under (d)1 above), determine the heat input (in MMBTU) that the combustion source derived from the combustion of that fuel during the base year;

3. Determine the maximum allowable NO_x emissions rate (in lb/MMBTU) for the combustion of each fuel, under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, as applicable;

4. For each fuel, multiply the heat input in the base year (determined under (d)2 above) by the maximum allowable emissions rate (determined under (d)3 above);

5. Add all of the amounts determined under (d)4 above;

6. Divide the total determined under (d)5 above by the sum of all of the heat inputs that the combustion source derived from the combustion of each fuel (determined under (d)2 above). The result is the maximum allowable NO_x emission rate, expressed in lb/MMBTU, provided, however, that the maximum allowable NO_x emission rate shall not be greater than the rate under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would apply if the combustion source were combusting the primary fuel that it had used in the base year;

7. The calculations under (d)4, 5 and 6 above can be expressed in the following equation:

$$M = \frac{(HI_1 L_1) + (HI_2 \times L_2) + \ldots + (HI_N \times L_N)}{(HI_1 + HI_2 + \ldots + HI_N)}$$

where:

i. M is the maximum allowable NO_x emission rate, in lb/MMBTU;

ii. HI_1 is the heat input that the combustion source derived from the combustion of Fuel 1 during the base year, expressed in MMBTU;

iii. L_1 is the maximum allowable emissions rate (in lb/MMBTU) for the combustion of Fuel 1, under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, as applicable;

iv. HI_2 is the heat input that the combustion source derived from the combustion of Fuel 2 during the base year, expressed in MMBTU;

v. L_2 is the maximum allowable emissions rate (in lb/MMBTU) for the combustion of Fuel 2, under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, as applicable;

vi. N is number of fuels combusted during the base year;

vii. HI_N is the heat input that the combustion source derived from the combustion of Fuel N during the base year, expressed in MMBTU; and

viii. L_N is the maximum allowable emissions rate (in lb/MMBTU) for the combustion of Fuel N, under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, as applicable.

(e) The Department shall approve a plan for fuel switching only if the application satisfies all requirements of (c) above and N.J.A.C. 7:27-19.14. A plan for fuel switching shall be deemed to meet these requirements if it provides for a combustion source to attain compliance with the emission limits under (g)3, 4 and 5 below partly through combustion of cleaner fuel and partly through the use of other NO_x control measures, and satisfies all other requirements of (c) above and N.J.A.C. 7:27-19.14.

(f) Any owner or operator seeking to comply with this subchapter by fuel switching in accordance with this section shall obtain the Department's written approval of the application pursuant to N.J.A.C. 7:27-19.14 before May 1, 1995, and maintain that approval in effect.

(g) Beginning in calendar year 1995, the owner or operator shall operate each combustion source included in the plan in compliance with the following:

1. All conditions of the Department's written approval of the fuel switching plan shall be met;

2. From May 1 through September 15 of each year, the combustion source shall combust the cleaner fuel exclusively, or derive a higher percentage of its total heat input from cleaner fuel than the percentage it derived from May 1 through September 15 of the base year;

3. During each calendar day from May 1 through September 15 of each year, the combustion source shall emit NO_x at an average rate no higher than the maximum allowable NO_x emission rate determined under (d) above; provided however, that a coal-fired, wet-bottom utility boiler that uses the tangential or face firing method, the maximum allowable NO_x emission rate shall be 1.0 lb/MMBTU;

4. During the 30-day period ending on September 16 of each year, and each 30-day period ending on each subsequent day thereafter until April 30 of the following year, the combustion source shall emit NO_x at an average rate no higher than the rate under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would apply if the combustion source were combusting the primary fuel that it had used in the base year; provided however, that a coal-fired, wet-bottom utility boiler that uses the tangential or face firing method shall emit NO_x at a rate no higher than 1.5 lb/MMBTU; and

5. During each calendar year, the combustion source shall emit NO_x at an average rate no higher than the maximum NO_x emission rate determined under (d) above; provided however, that a coal-fired, wet-bottom utility boiler that uses the tangential or face firing method shall emit NO_x at a rate no higher than 1.5 lb/MMBTU. Compliance with this requirement shall be determined based on averaging over each calendar year.

(h) The owner or operator shall determine the NO_x emissions from each combustion source included in an approved fuel switching plan in accordance with N.J.A.C. 7:27-19.15(a).

(i) The owner or operator shall demonstrate compliance with this section as follows:

1. Each calendar day from May 1 through September 15 of each year, the owner or operator shall determine whether each combustion source included in the plan is in compliance with the applicable daily NO_x emission limit under (g)3 above. The owner or operator shall perform the calculations necessary to verify compliance and make a record of them within three working days after the date that is the subject of the calculation;

2. For the 30-day period ending on September 16, and for each 30-day period ending on each subsequent day until April 30 of the following year, the owner and operator shall determine whether each combustion source included in the plan is in compliance with the applicable 30-day NO_x emission limit under (g)4 above; and

3. By January 15 of each year, the owner or operator shall determine whether the total actual NO_x emissions from each combustion source included in the plan (determined under (k) below) complied with the limit on annual NO_x emissions (determined under (j) below) during the preceding calendar year.

(j) The limit on annual NO_x emissions is calculated as follows:

1. For each fuel that the combustion source combusted during the year, determine the heat input (in MMBTU) that the combustion source derived from the combustion of that fuel during the year;

2. Add all of the amounts determined under (j)1 above;

3. Multiply the sum determined under (j)2 above by the maximum NO_x emissions rate determined under (d) above. The result is the limit on annual NO_x emissions, expressed in pounds;

4. The calculations under (j)2 and 3 above can be expressed in the following equation:

$$L = M \times (AHI_1 + AHI_2 + \ldots + AHI_N)$$

where:

i. L is the limit on annual NO_x emissions, in pounds;

ii. M is the maximum allowable emissions rate determined under (d) above;

iii. AHI_1 is the heat input that the combustion source derived from the combustion of Fuel 1 during the year, expressed in MMBTU;

iv. AHI_2 is the heat input that the combustion source derived from the combustion of Fuel 2 during the year, expressed in MMBTU;

v. N is number of fuels combusted during the year; and

vi. AHI_N is the heat input that the combustion source derived from the combustion of Fuel N during the year, expressed in MMBTU.

(k) The actual annual NO_x emissions from the combustion source are calculated as follows:

1. Determine the heat input (expressed in MMBTU) that the combustion source actually derived from each fuel it combusted during the year;

2. Determine the average rate (in lb/MMBTU) at which the combustion source actually emitted NO_x when combusting each fuel listed in 1 above, in accordance with N.J.A.C. 7:27-19.15(a);

3. For each fuel combusted during the year, multiply the heat input (determined under (k)1 above) by the average rate of NO_x emissions (determined under (k)2 above);

4. Add all of the amounts determined under (k)3 above;

5. The calculations under (k)3 and 4 above can be expressed in the following equation:

$$AE = (AHI_1 \times AR_1) + (AHI_2 \times AR_2) + \ldots + (AHI_N \times AR_N)$$

where:

i. AE is the actual NO_x emissions during the year from the combustion source, expressed in pounds;

ii. AHI_1 is the heat input that the combustion source actually derived from the combustion of Fuel 1 during the year, expressed in MMBTU;

iii. AR_1 is the average rate at which the combustion source actually emitted NO_x when combusting Fuel 1 during the year, expressed in lb/MMBTU;

iv. AHI_2 is the heat input that the combustion source actually derived from the combustion of Fuel 2 during the year, expressed in MMBTU;

v. AR_2 is the average rate at which the combustion source actually emitted NO_x when combusting Fuel 2 during the year, expressed in lb/MMBTU;

vi. N is number of fuels that the combustion source actually combusted;

vii. AHI_N is the heat input that the combustion source actually derived from the combustion of Fuel N during the year, expressed in MMBTU; and

viii. AR_N is the average rate at which the combustion source actually emitted NO_x when combusting Fuel N during the year, expressed in lb/MMBTU.

(l) For each combustion source included in the approved plan, the owner or operator shall comply with the recordkeeping and reporting requirements of N.J.A.C. 7:27-19.19.

7:27-19.21 Phased compliance—repowering

(a) The owner or operator of a combustion source included in a repowering plan is authorized to comply with the plan if the Department approves the plan pursuant to this section and N.J.A.C. 7:27-19.14. The owner or operator's compliance with the plan is in lieu of causing the combustion source to comply with emission limit under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would otherwise apply to the combustion source.

(b) By (date that is 30 days after operative date of these amendments), an owner or operator seeking approval of a repowering plan shall submit to the Department an application for approval of the repowering plan pursuant to N.J.A.C. 7:27-19.14, including a repowering plan pursuant to (c) below. If an owner or operator fails to submit the application by (date that is 30 days after operative date of these amendments), the Department may reject the application. The Department may elect to process a late application, based on how late the application is, the nature and extent of the owner or operator's efforts to submit the application on time, whether the owner or operator advised the Department before the application due date that a late application would be submitted, and the extent of the emission reductions promised in the late application. If the Department elects to process a late application, the pendency of the application shall not be a defense to a violation of a NO_x emission limit to which the source is subject in the absence of an approved plan.

(c) The owner or operator shall include the following information in the repowering plan with respect to each combustion source included in the plan:

1. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

2. A proposed schedule setting dates by which the owner or operator will complete the following milestones for the combustion source:

i. Submitting applications for all necessary permits and certificates;

ii. Obtaining all necessary permits and certificates;

iii. Awarding contracts to repower the source or placing orders for the purchase of component parts and/or equipment necessary to repower the source;

iv. Initiating construction and/or installation of the replacement unit; and

v. Completing the repowering.

3. Specific procedures and schedules for implementing interim measures for control of NO_x emissions for the combustion source during the interim period;

4. A list of all NO_x control technologies available for use with the combustion source;

5. An analysis of the technological feasibility of installing and operating each NO_x emission control technology identified in 4 above for the interim period;

6. For each control technology that is technologically feasible to install and operate, an estimate of the cost of installation and operation;

7. An estimate of the reduction in NO_x emissions attainable through the use of each control technology which is technologically feasible to install and operate. If a control technology installed before the combustion source is repowered cannot be used after repowering, the owner or operator may limit the estimate of emission reductions to those that will be attained during the interim period;

8. An analysis of the cost-effectiveness of each control technology, based on the costs of installation and operation under (c)6 above and the estimated emission reductions under (c)7 above;

9. The NO_x control measures that the owner or operator proposes to employ during the interim period;

10. The proposed interim NO_x emission limit with which the source will comply during the interim period;

11. The method to be used to measure the actual NO_x emission rate of the combustion source;

12. The name and business telephone number of the person responsible for recordkeeping and reporting under N.J.A.C. 7:27-19.19 and under (e)8 below;

13. The location of the proposed replacement unit; and

14. Any other information that the Department requests, which is reasonably necessary to enable it to determine whether the operation of combustion sources included in the repowering plan will comply with the requirements of this section.

(d) The Department shall approve a repowering plan only if the following requirements are satisfied:

1. The application satisfies all the requirements of N.J.A.C. 7:27-19.14 and (c) above, including without limitation the requirement that the proposed repowering plan consider all control technologies available for the control of NO_x emissions from each type of combustion source included in the plan during the interim period;

2. For each combustion source included in the plan, the replacement unit will incorporate advances in the art of air pollution control for the kind and amount of air contaminant emitted;

3. The repowering will improve the efficiency with which each combustion source included in the plan combusts fuel and/or generates power;

4. The completion date listed in (c)2v above is no later than May 1, 1999;

5. For any control technologies described in (c)4 above that the owner or operator does not propose to use on the combustion source, the proposed plan demonstrates that the control technology:

i. Would be ineffective in controlling NO_x emissions from the combustion source;

ii. Is unsuitable for use with the combustion source, or duplicative of control technology which the plan proposes to use;

iii. Would carry costs disproportionate to the improvement in the reduction of the NO_x emissions rate that the control technology is likely to achieve, or disproportionately large in comparison to the total reduction in NO_x emissions that the control technology is likely to achieve over its useful life; or

iv. Would carry costs disproportionate to the costs incurred for the control of NO_x emissions from the same type of combustion sources used by other persons in the owner or operator's industry who are also subject to the NO_x RACT requirements of P.L. 101-549, §182(f).

6. For each combustion source included in the plan, the interim emission limit proposed under (c)10 above is the lowest rate that can practicably be achieved at a cost within the limits described in (d)5iii and iv above;

7. For each combustion source included in the plan, the cost of achieving an additional emission reduction beyond the interim emission limit proposed under (c)10 above would be disproportionate to the size and environmental impact of that additional emission reduction; and

8. The owner or operator has entered into an agreement with the Department in accordance with the requirements of (h) below.

(e) An owner or operator who has obtained the Department's approval of a repowering plan shall:

1. Beginning on May 31, 1995, operate all combustion sources included in the approved repowering plan in a manner that complies with the plan and with all conditions of the Department's approval;

2. Meet the compliance milestones in the approved plan;

3. Repower the combustion sources included in the plan by the date specified in the approved plan;

4. Beginning on May 31, 1995, determine the actual NO_x emissions from each combustion source included in the repowering plan in accordance with N.J.A.C. 7:27-19.15(a);

5. If the approved plan provides for the owner or operator to annually adjust the combustion process for a combustion source included in the plan, do so in accordance with the general procedures set forth at N.J.A.C. 7:27-19.16 before May 1 of each calendar year beginning with 1995, until repowering is completed;

6. Beginning on May 31, 1995, comply with the recordkeeping and reporting requirements of N.J.A.C. 7:27-19.19;

7. Within 15 days after the date specified in the approved repowering plan for completion of a milestone listed in (c)2 above, notify the Department in writing that the milestone has or has not been completed. If the milestone has not been completed, the owner or operator shall include in the notice the reason for the delay and the expected date on which the milestone will be completed;

8. Incorporate advances in the art of air pollution control into each repowered source, as required in the preconstruction permit for the replacement equipment;

9. If the plan includes a utility boiler, cause the repowered utility boiler to emit NO_x at a rate no higher than the applicable maximum allowable NO_x listed in Table 6 below (provided however, that the NO_x emission limits in Table 6 shall not be construed to limit the owner or operator's obligations under (e)8 above); and

10. If repowering of any combustion source included in the plan is not completed by May 1, 1999, cease operating the combustion source to be repowered by May 1, 1999.

TABLE 6

Maximum Allowable NO_x Emission Rates for Utility Boilers Which Have Been Repowered (pounds per million BTU)

	Firing Method		
Fuel/Boiler Type	Tangential	Face	Cyclone
Coal—Wet Bottom	0.2	0.2	0.2
Coal—Dry Bottom	0.2	0.2	N/A
Oil and/or Gas	0.1	0.1	0.1
Gas Only	0.1	0.1	0.1

(f) Except as provided in (g) below:

1. The Department shall seek comments from the general public before making any final decision to approve or disapprove a proposed repowering plan. The Department shall publish notice of opportunity for public comment in a newspaper of general circulation in the area in which each combustion source included in the plan is located;

2. The Department shall submit any repowering plan (and agreement to repower) approved under this section to EPA, as a proposed revision to New Jersey's State Implementation Plan; and

3. Upon EPA's approval of the revision to New Jersey's State Implementation Plan, it shall be Federally enforceable. Plans listed under (g) below shall be Federally enforceable upon the issuance of the Department's approval.

(g) A repowering plan (and agreement to repower) approved under this section is not required to be submitted to EPA as a proposed revision to New Jersey's State Implementation Plan, if the plan provides that NO_x emissions from each combustion source included in the plan will be controlled during the interim period through one of the following methods:

1. Fuel switching under N.J.A.C. 7:27-19.20, using natural gas as the "cleaner fuel"; or

2. The use of selective non-catalytic reduction from May 1 through September 15 of each year.

(h) Before the Department approves a repowering plan, the owner or operator shall enter into a Federally enforceable agreement containing the following provisions:

1. Information sufficient to identify the owner or operator;

2. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

3. The owner or operator's undertaking of the following duties:

i. Completing the milestones listed in (c)2 above by specified dates;

ii. Ceasing to operate a combustion source if repowering is not completed by a date specified for that source;

iii. Implementing interim measures to control NO_x emissions from each combustion source during the interim period;

iv. Causing each combustion source to emit NO_x at a rate no greater than a specified interim NO_x emission limit applicable during the interim period;

v. Using a specified method to measure the actual NO_x emission rate of the combustion source; and

vi. Maintaining the Department's approval in effect;

4. A provision for delay of compliance caused by a "force majeure" event beyond the control of and without the fault of the owner or operator;

5. A provision under which the Department can terminate the agreement and its approval of the repowering plan if the owner or operator materially fails to complete the repowering or any other milestone by the date specified in the approved plan. Termination of the agreement and the approval of the plan is in addition to any other remedies the Department has under this chapter and N.J.A.C. 7:27A; and

6. Other provisions necessary to make the agreement Federally enforceable, to accomplish the purposes of this subchapter, or to allow the agreement to be administered effectively.

7:27-19.22 Phased compliance—impracticability of full compliance by May 31, 1995

(a) The owner or operator of a combustion source included in a phased compliance plan is authorized to comply with the plan if the Department approves the planp ursuant to this section and N.J.A.C. 7:27-19.14. The owner or operator's compliance with the plan is in lieu of causing the combustion source to comply with the emission limit under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would otherwise apply to the combustion source.

(b) By (date that is 30 days after operative date of these amendments), an owner or operator seeking approval of a phased compliance plan shall submit to the Department an application for approval of the phased compliance plan pursuant to N.J.A.C. 7:27-19.14. If an owner or operator fails to submit the application by (date that is 30 days after operative date of these amendments), the Department may reject the application. The Department may elect to process a late application, based on how late the application is, the nature and extent of the owner or operator's efforts to submit the application on time, and whether the owner or operator advised the Department before the application due date that a late application would be submitted. If the Department elects to process a late application, the pendency of the application shall not be a defense to a violation of a NO_x emission limit to which the source is subject in the absence of an approved plan. In the application, the owner or operator shall include the following information in addition to the information required under N.J.A.C. 7:27-19.14:

1. The phased compliance plan described in (c) below;

2. A description of the steps that the owner or operator has taken to cause each combustion source included in the plan to attain compliance with the applicable NO_x emission limit under this subchapter; and

3. For each combustion source included in the plan, a detailed explanation of the reasons why the owner or operator believes that compliance with the applicable NO_x emission limit by May 31, 1995 is impracticable.

(c) The owner or operator shall include the following information in the phased compliance plan with respect to each combustion source included in the plan:

1. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

2. A proposed schedule setting dates by which the owner or operator will complete the following milestones for the combustion source:

i. Submit applications for all necessary permits and certificates;

ii. Obtain all necessary permits and certificates;

iii. Award contracts for the implementation of control measures or place orders for the purchase of component parts, equipment and/or control apparatus necessary to attain compliance with the applicable NO_x emission limit under this subchapter;

iv. Initiate construction and/or installation of the component parts, equipment and/or control apparatus necessary to attain compliance with the applicable NO_x emission limit under this subchapter; and

v. Attain full compliance with the applicable NO_x emission limit under this subchapter;

3. The NO_x control measures or technology that the owner or operator proposes to employ during the interim period; and

4. Any other information that the Department requests, which is reasonably necessary to enable it to determine whether the operation of combustion sources included in the phased compliance plan will comply with the requirements of this section.

(d) The Department shall approve a phased compliance plan only if the following requirements are satisfied with respect to each combustion source included in the plan:

1. The application satisfies all the requirements of N.J.A.C. 7:27-19.14 and (b) above;

2. The information submitted under (b)1ii above establishes that the owner or operator has made a good faith effort to cause the combustion source to attain compliance with the applicable NO_x emission limit under this subchapter;

3. The information submitted under (b)1iii above, evaluated in light of the criteria set forth in (e) below, establishes that it is impracticable for the combustion source to attain compliance with the applicable NO_x emission limit under this subchapter by May 31, 1995; and

4. The interim period is less than 12 months.

(e) In determining whether compliance with the applicable NO_x emission limit under this subchapter by May 31, 1995 is impracticable, the Department shall apply the following criteria:

1. The amount of time needed to obtain all permits and certificates necessary to attain compliance, following the submission of an administratively complete application;

2. The amount of time needed to obtain all component parts and/or equipment necessary to attain compliance, following the placement of orders for such parts and/or equipment. The estimate of time may reflect shortages in the supply of such parts and/or equipment;

3. The amount of time needed to complete construction and/or installation of the component parts and/or equipment necessary to attain compliance, following the initiation of construction and/or installation; and

4. The nature, extent and probability of any harm to public safety or welfare that could result from accelerating construction and/or installation in order to attain compliance by May 31, 1995. For example, if it were probable that an electric generating utility could not cause all of its electric generating units to attain compliance by that date without subjecting a substantial number of customers to voltage reductions and/or interruptions in electric service, that fact would be relevant in establishing impracticability.

(f) On the date that the approved compliance plan provides for a combustion source to attain full compliance with the applicable NO_x emission limit under this subchapter, the Department's approval of the plan shall expire. Upon expiration of the Department's approval, the combustion source shall be subject to all applicable requirements of this subchapter, including the NO_x emission limits that would have applied to the source in the absence of an approved plan.

(g) An owner or operator who has obtained the Department's approval of a phased compliance plan shall:

1. Operate all combustion sources included in the plan in a manner that complies with the plan and with all conditions of the Department's approval;

2. Meet all milestones in the approved phased compliance plan;

3. Within 15 days after the date of each milestone in the approved phased compliance plan, advise the Department in writing whether the owner or operator has met the milestone; and

4. During the interim period, control NO_x emissions from the combustion source as follows:

i. By adjusting the combustion process in accordance with N.J.A.C. 7:27-19.16, if the source's air-to-fuel ratio can be adjusted in a manner that reduces NO_x emissions; or

ii. By seasonally combusting natural gas in accordance with N.J.A.C. 7:27-19.20, implementing selective non-catalytic reduction, or implementing other measures that the Department determines are appropriate in light of the costs involved and the total quantity of NO_x reductions that will be achieved until the full compliance date listed in (c)2v above.

7:27-19.23 Phased compliance—use of innovative control technology

(a) The owner or operator of a combustion source included in a phased compliance plan is authorized to comply with the plan if the Department approves the planp ursuant to this section and N.J.A.C. 7:27-19.14. The owner or operator's compliance with the plan is in lieu of causing the combustion source to comply with the emission limit under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10 that would otherwise apply to the combustion source.

(b) By (30 days after operative date of these amendments), an owner or operator seeking approval of an innovative control technology plan shall submit to the Department an application pursuant to N.J.A.C. 7:27-19.14 and the plan itself pursuant to (c) below. If an owner or operator fails to submit the application by (30 days after operative date of these amendments), the Department may reject the application. The Department may elect to process a late application, based on how late the application is, the nature and extent of the owner or operator's efforts to submit the application on time, whether the owner or operator advised the Department before the application due date that a late application would be submitted, and the extent of the emission reductions promised in the late application. If the Department elects to process a late application, the pendency of the application shall not be a defense to a violation of a NO_x emission limit to which the source would be subject in the absence of an approved plan.

(c) The owner or operator shall include the following information in the innovative control technology plan with respect to each combustion source included in the plan:

1. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

2. A description of the NO_x control measures that the owner or operator proposes to employ as innovative control technology;

3. The rate of NO_x emissions that the owner or operator expects that the source will attain in employing the proposed innovative control technology, and the basis for that expectation;

4. Information establishing that the proposed innovative control technology is technically sound and sufficiently developed to be implemented by May 1, 1999;

5. A proposed schedule setting dates by which the owner or operator will complete the following milestones for the combustion source:

i. Submitting applications for all necessary permits and certificates;

ii. Obtaining all necessary permits and certificates;

iii. Awarding contracts for the implementation of the innovative control technology, or placing orders for the purchase of any component parts, equipment and/or control apparatus associated with the innovative control technology;

iv. Awarding contracts and initiating implementation of the innovative control technology (including any construction and/or installation, if applicable); and

v. Completing the implementation of the innovative control technology.

6. Specific procedures and schedules for implementing interim measures for control of NO_x emissions for the combustion source during the interim period;

7. A list of all NO_x control technologies available for interim use with the combustion source during the interim period;

8. An analysis of the technological feasibility of installing and operating each NO_x emission control technology identified in (c)7 above for the interim period;

9. For each control technology that is technologically feasible to install and operate, an estimate of the cost of installation and operation;

10. An estimate of the reduction in NO_x emissions attainable through the use of each control technology which is technologically feasible to install and operate. If a control technology installed before the innovative control technology is implemented cannot be used after that time, the owner or operator may limit the estimate of emission reductions to those that will be attained during the interim period;

11. An analysis of the cost-effectiveness of each control technology, based on the costs of installation and operation under (c)9 above and the estimated emission reductions under (c)10 above;

12. The NO_x control measures that the owner or operator proposes to employ during the interim period;

13. The proposed interim NO_x emission limit with which the source will comply during the interim period;

14. The method to be used to measure the actual NO_x emission rate of the combustion source;

15. The name and business telephone number of the person responsible for recordkeeping and reporting under N.J.A.C. 7:27-19.19 and under (e)8 below; and

16. Any other information that the Department requests, which is reasonably necessary to enable it to determine whether the operation of combustion sources included in the plan will comply with the requirements of this section.

(d) The Department shall approve an innovative control technology plan only if the following requirements are satisfied:

1. The application satisfies all the requirements of N.J.A.C. 7:27-19.14 and (c) above, including the requirement that the plan consider all control technologies available for the control of NO_x emissions during the interim period from each type of combustion source included in the plan;

2. The innovative control technology proposed for each combustion source in the plan:

i. Has a substantial likelihood of enabling the source to achieve greater continuous NO_x emissions reductions than are required to meet the applicable limit under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10. If the expected extent of NO_x emission reductions is only marginally greater than are required to meet the applicable limit, the proposed innovative control technology will not be deemed to meet this standard;

ii. Is technically sound;

iii. Is sufficiently developed so that it can be implemented by May 1, 1999; and

iv. Cannot practicably be implemented by May 31, 1995.

3. The completion date listed in (c)5v above is no later than May 1, 1999;

4. For any control technologies described in (c)7 above that the owner or operator does not propose to use with the combustion source during the interim period, the proposed plan demonstrates that the control technology:

i. Would be ineffective in controlling NO_x emissions from the combustion source;

ii. Is unsuitable for use with the combustion source, or duplicative of control technology which the plan proposes to use;

iii. Would carry costs disproportionate to the improvement in the reduction of the NO_x emissions rate that the control technology is likely to achieve, or disproportionately large in comparison to the total reduction in NO_x emissions that the control technology is likely to achieve during the interim period; or

iv. Would carry costs disproportionate to the costs incurred for the control of NO_x emissions from the same type of combustion sources used by other persons in the owner or operator's industry who are also subject to the NO_x RACT requirements of P.L. 101-549, 182(f).

5. For each combustion source included in the plan, the interim emission limit proposed under (c)13 above is the lowest rate that can practicably be achieved at a cost within the limits described in (d)4iii and iv above;

6. For each combustion source included in the plan, the cost of achieving an additional emission reduction beyond the interim emission limit proposed under (c)13 above would be disproportionate to the size and environmental impact of that additional emission reduction; and

7. The owner or operator has entered into an agreement with the Department in accordance with the requirements of (h) below.

(e) An owner or operator who has obtained the Department's approval of an innovative control technology plan shall:

1. Beginning on May 31, 1995, operate all combustion sources included in the approved plan in a manner that complies with the plan and with all conditions of the Department's approval;

2. Meet the compliance milestones in the approved plan;

3. Implement the innovative control technology for the combustion sources included in the plan by the date specified in the approved plan;

4. Beginning on May 31, 1995, determine the actual NO_x emissions from each combustion source included in the innovative control technology plan in accordance with N.J.A.C. 7:27-19.15(a);

5. If the approved plan provides for the owner or operator to annually adjust the combustion process for a combustion source included in the plan, do so in accordance with the general procedures set forth at N.J.A.C. 7:27-19.16 before May 1 of each calendar year beginning with 1995, until the innovative control technology is implemented;

6. Beginning on May 31, 1995, comply with the recordkeeping and reporting requirements of N.J.A.C. 7:27-19.19;

7. Within 15 days after the date specified in the approved innovative control technology plan for completion of a milestone listed in (c)5 above, notify the Department in writing that the milestone has or has not been completed. If the milestone has not been completed, the owner or operator shall include in the notice the reason for the delay and the expected date on which the milestone will be completed;

8. Incorporate advances in the art of air pollution control into each source included in the plan, as required in the preconstruction permit for the replacement equipment; and

9. If the innovative control technology for any combustion source included in the plan is not implemented by May 1, 1999, cease operating the combustion source by May 1, 1999.

(f) Except as provided in (g) below:

1. The Department shall seek comments from the general public before making any final decision to approve or disapprove a proposed innovative control technology plan. The Department shall publish notice of opportunity for public comment in a newspaper of general circulation in the area in which each combustion source included in the plan is located;

2. The Department shall submit any innovative control technology plan (and agreement under (h) below) approved under this section to EPA, as a proposed revision to New Jersey's State Implementation Plan; and

3. Upon EPA's approval of the revision to New Jersey's State Implementation Plan, the innovative control technology plan and agreement under (h) below shall be federally enforceable. Plans listed under (g) below shall be federally enforceable upon the issuance of the Department's approval.

(g) An innovative control technology plan approved under this section is not required to be submitted to EPA as a proposed revision

to New Jersey's State Implementation Plan, if the plan provides that NO_x emissions from each combustion source included in the plan will be controlled during the interim period through one of the following methods:

1. Fuel switching under N.J.A.C. 7:27-19.20;

2. The use of selective non-catalytic reduction.

(h) Before the Department approves an innovative control technology plan, the owner or operator shall enter into a Federally enforceable agreement containing the following provisions:

1. Information sufficient to identify the owner or operator;

2. Information sufficient to identify the combustion source, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, the company stack designation, and any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the owner or operator;

3. The owner or operator's undertaking of the following duties:

i. Completing the milestones listed in (c)5 above by specified dates;

ii. Implementing interim measures to control NO_x emissions from each combustion source during the interim period;

iii. Causing each combustion source to emit NO_x at a rate no greater than a specified interim NO_x emission limit applicable during the interim period;

iv. Using a specified method to measure the actual NO_x emission rate of the combustion source; and

v. Maintaining the Department's approval in effect;

4. A provision for delay of compliance caused by a "force majeure" event beyond the control of and without the fault of the owner or operator;

5. A provision under which the Department can terminate the agreement and its approval of the innovative control technology plan if the owner or operator materially fails to complete implementation of the innovative control technology or any other milestone by the date specified in the approved plan, or if the innovative control technology program fails to achieve the required reduction levels. By the date specified by the Department in the agreement, in ts approval of the plan, or in the notice of termination, the owner or operatorshall attain compliance with the NO_x emissions limit under this subchapter that would apply to the combustion source in the absence of an approved plan. Termination of the agreement and the approval of the plan is in addition to any other remedies the Department has under this chapter and N.J.A.C. 7:27A; and

6. Other provisions necessary to make the agreement federally enforceable, to accomplish the purposes of this subchapter, or to allow the agreement to be administered effectively.

7:27-19.24 MEG alerts

(a) During a MEG alert that occurs on or before November 15, 2005, an electric generating unit that is operating at emergency capacity may exceed the NO_x emissions limits applicable under this subchapter. This exemption is available only if the electric generating utility that owns or operates the electric generating unit complies with the requirements of this section.

(b) Within two working days after the end of the MEG alert, the electric generating utility shall deliver (as opposed to send) to the Department a report confirming the occurrence of the MEG alert. The electric generating utility shall certify the report in accordance with N.J.A.C. 7:27-8.24. In the report, the electric generating utility shall include the following information:

1. Information sufficient to identify each electric generating unit that operted at emergency capacity, including a brief description (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the utility;

2. The date and time at which the electric generating utility received notice from the load dispatcher, directing the utility to operate one or more electric generating units at emergency capacity;

3. For each electric generating unit listed in (b)1 above, the date and time at which the electric generating utility began to operate the electric generating unit at emergency capacity;

4. The date and time at which the electric generating utility received notice from the load dispatcher, advising the utility that it could cease operating its electric generating units at emergency capacity;

5. For each electric generating unit listed in (b)1 above, the date and time at which the electric generating utility ceased operating the electric generating unit at emergency capacity;

6. For each electric generating unit listed in (b)1 above, the amount by which the unit's NO_x emissions (expressed in pounds) during the MEG alert exceeded the maximum quantity of NO_x emissions allowed under this subchapter. The excess NO_x emissions shall be calculated as follows for each day that the MEG alert continued:

$$E = (ER–M) \times H$$

where:

i. E is the excess NO_x emissions from the electric generating unit;

ii. ER is the average rate at which the electric generating unit emitted NO_x during the day of the MEG alert, determined in accordance with N.J.A.C. 7:27-19.15(a) and expressed in lb/MMBTU;

iii. M is the NO_x emissions limit applicable under N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, or an applicable NO_x emission limit established under N.J.A.C. 7:27-19.13, 19.20, 19.21, 19.22 or 19.23, expressed in lb/MMBTU; and

iv. H the actual daily heat input to the electric generating unit during the MEG alert, expressed in MMBTU;

7. A copy of the calculations performed under (b)6 above; and

8. A description of the method by which the electric generating utility has provided or will provide compensatory reductions in NO_x emissions as required under (c) below.

(c) The electric generating utility shall submit to the Department documentation of actual NO_x emission reductions in compensation for the excess NO_x emissions during the MEG alert, in accordance with the following requirements:

1. Within the period beginning three years before the MEG alert begins and ending one year after the MEG alert ends, the electric generating utility shall obtain (or shall have obtained) reductions in NO_x emissions from a combustion source through measures (which may include pollution prevention measures) above and beyond those required under any Federal or State law, rule, regulation, permit or order.

2. The ratio of the amount of the NO_x emission reductions under (c)1 above to the amount of the excess NO_x emissions calculated under (b)6 above shall be 1.3:1; and

3. Emissions reductions from any shutdown or curtailment of operations of a combustion source shall not be credited toward meeting this requirement.

7:27-19.25 Exemption for emergency use of fuel oil

(a) If a combustion source temporarily combusts fuel oil or other liquid fuel in place of natural gas in accordance with this section, the owner or operator is not required to have the combustion source comply with the applicable NO_x emission limits in N.J.A.C. 7:27-19.4, 19.5, 19.7, 19.8, 19.9 or 19.10, or an applicable NO_x emission limit established under N.J.A.C. 7:27-19.13, 19.20, 19.21, 19.22 or 19.23, while the fuel oil or other liquid fuel is burned. On each day that this exemption applies, for purposes of calculating daily or annual NO_x emissions the combustion source will be deemed to have emitted no NO_x and to have derived a heat input of 0.0 BTU.

(b) The exemption under (a) above is available only for a combustion source that uses natural gas as its primary fuel, or is seasonally combusting natural gas pursuant to a plan approved under N.J.A.C. 7:27-19.14 and 19.20. For a combustion source that uses natural gas as its primary fuel, the exemption under (a) above is available at any time during the year. For a combustion source that is seasonally combusting natural gas, the exemption under (a) above is available only from May 1 through September 15.

(c) The owner or operator of the combustion source is eligible for the exemption under (a) above only if the following requirements are met:

1. The owner or operator is not practicably able to obtain a sufficient supply of natural gas;

2. The owner or operator's inability to obtain natural gas is due to circumstances beyond the control of the owner or operator, such as a natural gas curtailment;

3. The combustion source ceases using fuel oil or other liquid fuel in place of natural gas and resumes using natural gas as soon as a sufficient supply of natural gas becomes practicably available;

4. The use of fuel oil or liquid fuel does not exceed 500 hours during any consecutive 12-month period; and

5. The owner or operator satisfies the recordkeeping requirements of N.J.A.C. 7:27-19.19(d) and (e), and the reporting requirements of (d) below.

(d) Within two days after beginning to combust fuel oil or other liquid fuel in place of natural gas in accordance with this section, the owner or operator shall send a written notice to the Department at the address designated in N.J.A.C. 7:27-19.3(h). In the notice, the owner or operator shall include the following information:

1. Information sufficient to identify each combustion source for which the owner or operator claims an exemption under this section, including a brief description of the source (for example, "dry-bottom coal-fired utility boiler"), its location, its permit number, any other identifying numbers, and any other information necessary to distinguish it from other equipment owned or operated by the utility;

2. A statement that the owner or operator is not practicably able to obtain a sufficient supply of natural gas;

3. The date and time at which the owner or operator first became practicably unable to obtain natural gas; and

4. A description of the circumstances causing the owner or operator's inability to obtain natural gas.

7:27-[19.20]**19.26** (No change in text.)

7:27A-3.10 Civil administrative penalties for violations of rules adopted pursuant to the Act

(a)-(d) (No change.)

(e) The Department shall determine the amount of the civil administrative penalty for offenses described in this section on the basis of the provision violated and the frequency of the violation. Footnotes 3, 4, and 8 set forth in this subsection are intended solely to put violators on notice that in addition to any civil administrative penalty assessed the Department may also revoke an operating certificate or variance. These footnotes are not intended to limit the Department's discretion in determining whether or not to revoke an operating certificate or variance, but merely indicate the situations in which the Department is most likely to seek revocation. The number of the following subsections correspond to the number of the corresponding subchapter in N.J.A.C. 7:27.

1.-18. (No change.)

19. The violations of N.J.A.C. 7:27-19, Control and Prohibition of Air Pollution from Oxides of Nitrogen, and the civil administrative penalty amounts for each violation are as set forth in the following table:

Citation	[Class] Rule Summary	First Offense	Second Offense	Third Offense	Fourth and Each Subsequent Offense
N.J.A.C. 7:27-19.3(d)	**Failure to Submit Application or Plan**	**$ 2,000**	**$ 4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-19.4(a)	Utility Boilers				
	Actual Emissions (pounds per million BTU): 1.-3. (No change).				
[N.J.A.C. 7:27-19.4(b)3 and (b)4i	Utility Boilers Seasonally combusting Natural Gas				
	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.4(b)4ii and (b)5	Actual Emissions (pounds per million BTU):				
	1. Less than 25 percent over the allowable standard	$ 8,000	$16,000	$40,000	$50,000
	2. From 25 through 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
	3. Greater than 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.4(c)1	Adjust combustion process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.4(c)2	Repowered Utility Boilers				
	Actual Emissions (pounds per million BTU):				
	1. Less than 25 percent over the allowable standard	$ 8,000	$16,000	$40,000	$50,000
	2. From 25 through 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
	3. Greater than 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.4(c)6	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000]
N.J.A.C. 7:27-19.4[(d)](**b**)	All Utility Boilers				
	Failure to Install CEM	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.5(a) or (b)	Stationary Gas Turbines				
	Actual Emission (pounds per million BTU):				
	3-10 MW Turbine				
	1.-3. (No change).				
	11-50 MW Turbine				
	1.-3. (No change).				
	Greater than 50 MW Turbine				
	1.-3. (No change).				

N.J.A.C. 7:27-19.5(c)5	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.5(c)6	Adjust Combustion Process	$ 2,000	$ 4,000	$10,000	$30,000
[N.J.A.C. 7:27-19.5(d)	CO concentration				
	Maximum Actual Emissions				
	1. Less than 25 percent over the allowable standard	$ 2,000	$ 4,000	$10,000	$30,000
	2. From 25 through 50 percent over the allowable standard	$ 4,000	$ 8,000	$20,000	$50,000
	3. Greater than 50 percent over the allowable standard	$ 8,000	$16,000	$40,000	$50,000]
N.J.A.C. 7:27-19.6(d)1 and 2	**Emissions** Averaging [for electric generating utilities]				
	Actual Emission (pounds per million BTU):				
	1. Less than 25 percent over the allowable standard	$ 8,000	$16,000	$40,000	$50,000
	[2. From 25 through 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
	3. Greater than 50 percent over the allowable standard	$10,000	$20,000	$50,000	$50,000]
	2. Twenty-five percent or greater percent over the allowable standard	**$10,000**	**$20,000**	**$50,000**	**$50,000**
N.J.A.C. 7:27-19.6(f)1 or 2	Record Keeping of Compliance Demonstration	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.6(g)	Log	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.6(h)	Quarterly Reports	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.6(i)	[Notification] **Notice** of Noncompliance	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.6(j)1	[Notification—Inoperable Boiler or Turbine] **Provide Notice of Ceased Operations**	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.7(a)	Adjust combustion process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.7(b) or (c)	Non-Utility boilers **and other indirect heat exchangers**				
	Actual Emission (pounds per million BTU):				
	Less than 25 MMBTU				
	1.-3. (No change).				
	25-57 MMBTU				
	1.-3. (No change).				
	Greater than 57 MMBTU				
	1.-3. (No change).				
N.J.A.C. 7:27-19.7(d)	**Heat input rate of 250 MMBTU per hour or greater**				
	Failure to install CEM	$10,000	$20,000	$50,000	$50,000
	Heat input rate of 50 MMBTU to less than 250 MMBTU per hour Adjust combustion process or install CEM	**$ 2,000**	**$ 4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-19.8(a),(b) or (c)	Stationary Internal Combustion Engines Actual Emission (grams per horsepower hour):				
	1000 Hp or less				
	1.-3. (No change).				
	Greater than 1000 Hp				
	1.-3. (No change).				
N.J.A.C. 7:27-19.9(a)	Asphalt Plants				
	Maximum Actual Emissions				
	1.-3. (No change).				
N.J.A.C. 7:27-19.9(b)	Adjust combustion process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.10(a) or (b)	Glass Manufacturing Furnaces				
	Maximum Actual Emission:				
	For less than 10 pounds per hour:				
	1.-3. (No change).				
	From 10 pounds through 22.8 pounds per hour:				
	1.-3. (No change).				

	From greater than 22.8 pounds per hour: 1.-3. (No change).				
N.J.A.C. 7:27-19.10(c)1	[Conduct Stack Test] **Determine baseline NO_x emission rate**	$ 2,000	$ 4,000	$10,000	$30,0000
N.J.A.C. 7:27-19.10(c)2	Submit Emission Reduction Plan	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.10(c)3	Implement Emission Reduction Plan	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.10(c)4	Reduce Emissions 30% Maximum Actual Emission: For less than 10 pounds per hour: 1.-3. (No change). From 10 pounds through 22.8 pounds per hour: 1.-3. (No change). From greater than 22.8 pounds per hour: 1.-3. (No change).				
N.J.A.C. 7:27-19.10(e)	Adjust combustion process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.13[(i)]**(j)**	Modify NO_x Control Plan for alterations	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.13[(m)]**(n)**	Implement NO_x Control Plan	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.15(c)	**Demonstrate Compliance**	**$ 2,000**	**$ 4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-19.16(c)	Log	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.17(a)1	Conduct Stack Tests	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.17(a)2,3 or 4	Information	$ 300	$ 600	$ 1,500	$ 4,500
N.J.A.C. 7:27-19.17(b)	Sampling and Testing Facilities	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.17(e)	Record keeping	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.18(a)2,3,4 or 5	Monitoring	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.18(h)	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.19(a) or (b)	Record keeping	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.19(d)	**Record keeping**	**$ 500**	**$ 1,000**	**$ 2,500**	**$ 7,500**
N.J.A.C. 7:27-19.19(e)	**Log**	**$ 500**	**$ 1,000**	**$ 2,500**	**$ 7,500**
N.J.A.C. 7:27-19.19(g)	**Submit Report**	**$ 500**	**$ 1,000**	**$ 2,500**	**$ 7,500**
N.J.A.C. 7:27-19.19(h)	**Submit Report**	**$ 500**	**$ 1,000**	**$ 2,500**	**$ 7,500**
N.J.A.C. 7:27-19.19(i)	**Notice of noncompliance**	**$ 500**	**$ 1,000**	**$ 2,500**	**$ 7,500**
N.J.A.C. 7:27-19.20(d)	**Compliance with Maximum Annual Emission Rate** **Actual Emissions (pounds per million BTU).** **1. Less than 25 percent over the allowable standard** **2. Twenty-five percent or greater percent over the allowable standard**	**$ 8,000** **$10,000**	**$16,000** **$20,000**	**$40,000** **$50,000**	**$50,000** **$50,000**
N.J.A.C. 7:27-19.20(g)1	**Conditions of Approval**	**$ 2,000**	**$ 4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-19.20(g)2	**Combust Cleaner Fuel**	**$ 2,000**	**$ 4,000**	**$10,000**	**$30,000**
N.J.A.C. 7:27-19.20(g)3	**Compliance with Maximum Allowable Emission Rate** **Actual Emissions (pounds per million BTU)** **1. Less than 25 percent over the allowable standard** **2. Twenty-five percent or greater percent over the allowable standard**	**$ 8,000** **$10,000**	**$16,000** **$20,000**	**$40,000** **$50,000**	**$50,000** **$50,000**
N.J.A.C. 7:27-19.20(g)4	**Compliance with Maximum Allowable Emission Rate** **Class: Utility Boilers** **See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.4(a).**				

	Class: Stationary Gas Turbines See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.5(a) or (b).				
	Class: Nonutility Boilers and other Indirect Heat Exchangers See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.7(b) or (c).				
	Class: Stationary Internal Combustion Engines See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.8(a), (b) or (c).				
	Class: Asphalt Plants See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.9(a).				
	Class: Glass Manufacturing Furnaces See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.10(a) or (b).				
N.J.A.C. 7:27-19.20(g)5	Compliance with Maximum Annual Emission Rate				
	Actual Emissions (pounds per million BTU).				
	1. Less than 25 percent over the allowable standard	$ 8,000	$16,000	$40,000	$50,000
	2. Twenty-five percent or greater percent over the allowable standard	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.20(i)1,2 or 3	Maintain Emission Calculations	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.21(e)1	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.21(e)2	Compliance Milestones	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.21(e)4	Determine Actual NO_x Emissions	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.21(e)5	Adjust combustion process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.21(e)6	Record Keeping and Reporting	$ 500	$1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.21(e)7	Notification	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.21(e)9	Compliance with Maximum Allowable Emission Rate				
	Class: Utility Boilers See N.J.A.C. 7:27A-3.10(e)19 for the calculation of civil administrative penalties for violations of N.J.A.C. 7:27-19.5(a) or (b).				
N.J.A.C. 7:27-19.21(e)10	Cease Operating	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.22(g)1	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.22(g)2	Compliance Milestones	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.22(g)3	Notification	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.22(g)4	Control Emissions	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)1	Conditions of Approval	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)2	Compliance Milestones	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)3	Implement Innovative Control Technology	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)4	Determine Actual NO_x Emissions	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)5	Adjust Combustion Process	$ 2,000	$ 4,000	$10,000	$30,000
N.J.A.C. 7:27-19.23(e)6	Record Keeping and Reporting	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.23(e)7	Notification	$ 500	$ 1,000	$ 2,500	$ 7,500

N.J.A.C. 7:27-19.23(e)9	Cease Operating	$10,000	$20,000	$50,000	$50,000
N.J.A.C. 7:27-19.24(b)	Report	$ 500	$ 1,000	$ 2,500	$ 7,500
N.J.A.C. 7:27-19.25(d)	Notification	$ 500	$ 1,000	$ 2,500	$ 7,500

HUMAN SERVICES

(a)

DIVISION OF FAMILY DEVELOPMENT

Child Care Services Manual

Proposed Readoption with Amendments: N.J.A.C. 10:15, 10:15A, 10:15B, and 10:15C

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A 30:1-12; 45 CFR, Parts 98 and 257; and the Americans with Disabilities Act (P.L. 101-336).

Proposal Number: PRN 1994-438.

Submit comments by September 14, 1994 to:
Marion E. Reitz, Director
Division of Family Development
CN 716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

In accordance with the sunset provisions of Executive Order No. 66(1978), the Department of Human Services (DHS) proposes to readopt N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C, which are set to expire on January 1, 1995. These rules comprise the Department of Human Services Child Care Services Manual which provides the framework for the Child Care and Development Block Grant (CCDBG) and the Title IV-A At Risk Child Care (ARCC) Programs as administered in New Jersey under the New Jersey Cares for Kids (NJCK) Child Care Certificate Program. The proposed readoption also includes amendments to N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C.

The Child Care and Development Block Grant of 1990, hereinafter referred to as CCDBG, is intended to increase the availability, affordability and quality of child care for low and moderate income families with a parent who is employed or attending a training or educational program. The program also provides for child care services for children in child protective services and foster care children, under the supervision of the Division of Youth and Family Services (DYFS), when such care is indicated as a necessary part of the child's treatment plan.

The Title IV-A At Risk Child Care Program, also known as "At-Risk" or ARCC, is intended to provide child care services to low-income working families who are not receiving Aid to Families with Dependent Children (AFDC) and need child care in order to work, and would otherwise be at risk of becoming eligible for AFDC.

The DHS has been designated the lead State agency responsible for the operation and administration of a Statewide comprehensive child care system that supports the needs of eligible families in the State. The DHS operates these child care service programs through the coordinated efforts of the Division of Family Development (DFD) and DYFS.

The U.S. Department of Health and Human Services Administration for Children and Families (ACF) has approved State Plans submitted by DHS for receipt of the State's share of the block grant monies first authorized under the Omnibus Budget Reconciliation Act (OBRA) 1990 to establish the child care service programs.

A summary of the text as well as an explanation of the amendments which have been proposed since the initial adoption are presented as follows:

N.J.A.C. 10:15 designates DHS as the lead State agency responsible for the administration and implementation of the Statewide comprehensive system of child care services and discusses funding sources administered within the framework of Federal regulation and State law in conjunction with existing programs available through DFD and DYFS. The general principles under which these child care service programs will operate and the responsibilities of the parent/applicant receiving child care services, as well as each faction involved in the administration of the programs are delineated.

N.J.A.C. 10:15A sets forth the general child care eligibility requirements for the CCDBG and ARCC programs, procedures to follow for child care arrangements and qualification criteria for various providers of child care services. Also presented in this subchapter is the requirement for a co-payment to be made toward the cost of child care by each family receiving such care.

N.J.A.C. 10:15B describes both the ARCC and the CCDBG programs. The chapter delineates the eligibility criteria required by families in order to receive ARCC or CCDBG benefits and explains how eligible families may access either program.

N.J.A.C. 10:15C details the provisions concerning the requirement that eligible families contribute a co-payment fee toward the cost of child care services. The chapter discusses the determination of the amount of the assessed co-payment fee. The chapter also delineates procedures required concerning collection, reporting and monitoring of the co-payment process.

A summary of the changes to N.J.A.C. 10:15 since its adoption are as follows:

1993

N.J.A.C. 10:15-1.2 and 10:15B-1.2 were amended to reflect the revised definitions of "low income" and "at risk" to include those up to 200 percent of the Federal Poverty Income Guidelines for program entry.

Tables I, II, and III at N.J.A.C. 10:15A-1.2(c) were amended to reflect revised age categories and revised maximum allowable child care payment rates. This section was also amended to reflect the revised source and address to which requests for copies of the maximum child care payment rates were to be made.

N.J.A.C. 10:15B-1.2(b)3 was amended to permit families to remain eligible under the ARCC program as long as the annual gross family income did not exceed 75 percent of the State Medial Income (SMI), thus paralleling the exit level with other DHS administered child care service programs.

N.J.A.C. 10:15C-1.1 was amended to reflect the revised co-payment scales.

1994

Tables I, II and III at N.J.A.C 10:15A-1.2(c) were amended to reflect the revised maximum allowable child care payment rates.

N.J.A.C. 10:15C-1.1(d) was amended to reflect the revised co-payment scales.

The following amendments are being proposed at this time as part of the proposed readoption of N.J.A.C. 10:15.

N.J.A.C. 10:15-1.1(b) reflects that the child care service programs are no longer in the planning stage of administration. All references to planning are being updated.

N.J.A.C. 10:15-1.1(c), 1.1(d), 1.9 and 2.1(a) reflect the abrogation of this Department's Office of Child Care Development.

N.J.A.C. 10:15-1.1(d) reflects compliance with final Federal regulations (45 CFR 98.20(3)) which indicate that: (1) established program eligibility criteria must clearly indicate that families of children in child protective service (CPS) under the supervision of DYFS residing in their own home may receive service in both the ARCC and CCDBG program, and (2) children in foster care under the supervision of DYFS are only eligible to receive services from the CCDBG program.

N.J.A.C. 10:15-1.1(d)11 reflects current activities conducted by DYFS regarding required efforts to promote employer-supported child care throughout the State.

N.J.A.C. 10:15-1.1(g) and 1.5 add current language as required by the Americans with Disabilities Act (P.L. 101-336). N.J.A.C 10:15-1.1(g) includes a reference to the DFD Family Development Program (FDP), deletes the reference to the now obsolete Urban Pre-Kindergarten program and replaces it with the Goodstarts program administered by the DHS and the Department of Education (DOE).

N.J.A.C. 10:15-1.2 includes and/or updates definitions for approved home, categories of care, child care centers, child protective services, co-payment, foster care, incapacitated parent, New Jersey Cares for Kids Child Care Certificate Program, Office of Child Care Development, protective service and special circumstances child. The terms were added

and/or revised to reflect accurate administration of the certificate program due to changes which may have occurred in the Federal or State regulations.

N.J.A.C. 10:15-1.6 adds language to reflect the confidential nature of information regarding CPS children.

N.J.A.C. 10:15-1.9(f)1i, 2.2(a)4 and 2.3(a)16 reflect current practice in the administration of the program which pertains to the rights of families affected by adverse actions in the delivery of child care service benefits through this program. Families affected by any adverse action to which they object, have the option to request a case review from the county designated child care agency and/or an administrative review with DFD. Following clarification of the final Federal regulations, this procedure was initiated in the program effective September 1, 1992 because the regulations which govern the certificate program clearly state that these programs are not entitlement programs such as AFDC, JOBS or Transitional Child Care. The ARCC and CCDBG programs are Federally funded programs which are governed by specific eligibility criteria as set forth in Federal regulations (see 45 CFR 98.20 and 45 CFR 257.30). The Federal eligibility criteria indicate that eligible parents enrolled in these child care programs do not have the same guarantees to the receipt of services as parents receiving services from entitlement programs. N.J.A.C. 10:15 was originally adopted prior to the adoption of the final Federal regulations governing these programs. Therefore, the original adoption made in concert with interim Federal regulations contained references to DFD fair hearings practices as set forth in N.J.A.C. 10:81-6 which proved to be inaccurate based on the final Federal regulations.

N.J.A.C. 10:15-1.9(f)6 establishes that employment, education and training organizations will receive a copy of this manual upon written request.

N.J.A.C. 10:15-2.1(a) deletes reference to the Department's Office of Child Care Development which was abolished and adds in its place that DFD and DYFS will assume the responsibilities of coordination and supervision of the CCDBG and ARCC programs.

N.J.A.C. 10:15-2.1(k) reflects the current usage of a portion of the Federal funds in the CCDBG program which are set aside for activities to improve the quality of child care. These activities may change yearly and are reflected in the DHS's yearly application for CCDBG funds. This is a requirement set forth in 45 CFR 98.51.

N.J.A.C. 10:15-2.2(a)2 clarifies DFD's responsibility in the supervision of the community-based organizations which administer the child care service programs.

N.J.A.C. 10:15-2.2(a)7 reflect current practice which now requires DFD to assume responsibility to conduct periodic local market rate surveys of child care arrangements. Previously, the DYFS held responsibility for conducting a local market rate survey of child care arrangements.

N.J.A.C. 10:15-2.2(b)3 and 4 clarifies current responsibilities of DYFS in the administration and supervision of the portion of the ARCC and CCDBG programs.

N.J.A.C. 10:15-2.3(a)14 reflects current program procedures. This proposed amendment eliminates the use of the term "certificates" and replaces it with a reference to "the applicable forms and materials used." As made allowable in the final Federal CCDBG regulations, to reduce the amount of paperwork required of a county designated child care agency and a parent/applicant, DFD eliminated the certificate form as a requirement. In its place, the necessary information was included on the Parent/Applicant/Provider Agreement which consolidated several initial forms into one.

N.J.A.C. 10:15-2.3(a)19 reflects current program practices regarding DYFS Child Protective Services (CPS) children. DFD and DYFS no longer require the county designated child care agency to establish a written agreement with the local DYFS District Office to provide services to CPS children and foster children under the supervision of DYFS. This agreement need not be established separately in writing because reference to this agreement is included as a specific requirement in the contract executed between DFD and the county designated agency.

N.J.A.C. 10:15-2.3(a)22 reflects current program practices. Due to Federal limitations placed on the amount of administrative dollars which the State can allocate to the county designated agencies to administer these programs, DHS does not require the agencies to verify a child's attendance at the child care arrangement. Monthly verification of a child's attendance by the county designated child care agency is considered by DFD to be an administrative burden which is very costly and time consuming. Therefore, to guard against the misuse of funds, the county designated child care agency is required, through a contract with DFD, to verify only that the parent/applicant and the child care provider have attested to the correct attendance of a child by signing the required attendance forms (voucher). After noting these signatures, the county designated child care agency authorizes the issuance of payment.

N.J.A.C. 10:15-2.4(c) deletes all references to the inclusion of co-payment information on the voucher form. This proposed amendment reflects current program operational practice which now includes co-payment on the Parent/Applicant/Provider Agreement. As indicated above, through consolidation of forms, the change was made in program operational procedures to reduce the amount of paperwork required of the county designated child care agency and the parent/applicant.

N.J.A.C. 10:15-2.4(e) is being added to guard against child care providers receiving other public subsidies for the same child for the same eligibility period.

N.J.A.C. 10:15-2.4(f) ensures that child care providers adhere to program requirements regarding the recoupment of payments. This rule is being added to guard against the misuse of program funds.

N.J.A.C. 10:15-2.4(g) ensures that child care providers issue a ten-day notice to the parent/applicant and to the county designated child care agency when a child is terminated from their care.

N.J.A.C. 10:15-2.4(h) requires child care providers to ensure compliance with regulatory licensure, registration or authorization requirements while in receipt of services from these programs.

N.J.A.C. 10:15-2.5(a)7 adds an assurance that the parent/applicant is responsible for all costs in excess of the maximum allowable payment rates. Pursuant to Federal regulations (45 CFR 257.21) states are required to adhere to established payment rates.

N.J.A.C. 10:15-2.5(a)8 ensures that a parent/applicant maintains compliance with program eligibility requirements (pertaining to employment, training, education or child protective service status and income) while in receipt of child care services.

N.J.A.C. 10:15-2.5(a)9 ensures that a parent/applicant complies with all requirements concerning the issuance and recoupment of payments.

At N.J.A.C. 10:15A amendments are being made to N.J.A.C. 10:15A-1.1(a), 1.1(b)3, 1.1(d), 1.1(d)5, 1.2(g), 1.5(a), 1.5(d) and 1.5(e) to reflect changes made as a result of the adoption of the final CCDBG and ARCC Federal regulations regarding children in CPS under the supervision of DYFS who live in their own homes and children in foster care placements under the supervision of DYFS.

The proposed amendments to these subsections clarify the program eligibility criteria and co-payment requirements for both groups of children pursuant to 45 CFR 98.20, 98.42 and 257.30(5). Families of CPS children under the supervision of DYFS who reside in their own home may receive services in both the ARCC and CCDBG programs. Children in foster care under the supervision of DYFS, may receive services from the CCDBG program only. The co-payment requirement may be waived for both groups of children, on a case-by-case basis.

N.J.A.C. 10:15A-1.1(a), 1.1(a)5ii, 1.2(f)1 and 1.2(g) clarify the program eligibility criteria regarding full-time employment and participation in full-time training and/or educational activities for ARCC and CCDBG. To remain eligible for services in ARCC, a family must need child care services in order to obtain full-time employment within a specified period or maintain full-time employment. To be eligible in CCDBG, a family must need child care in order to accept full-time employment, or full-time participation in training/educational activities or maintain full-time employment or full-time participation in training/educational activities or to participate/enter into multiple part-time educational/training activities and/or employment which combined equal full-time.

N.J.A.C. 10:15A-1.1(a) also deletes a reference to other child care service programs offered through DHS which are outlined in N.J.A.C. 10:81-14.18. This reference is deleted because DHS has offered many other child care service programs which were not identified in N.J.A.C. 10:81-14.18. Such a reference is not inclusive of all DHS administered child care service programs and could rapidly become outdated if included in the regulations. Since the reference serves no regulatory purpose, it is being removed.

N.J.A.C. 10:15A-1.1(a) and 1.1(d)5 also reflect language to clarify that fiscal resources must be available and Federal eligibility criteria must be met prior to the receipt of child care services in these programs.

N.J.A.C. 10:15A-1.1(a)3 reflects current practice in the operation of the program. The county designated child care agency is required by DFD to ensure that families placed on its waiting list, in accordance with established priorities for low income families, are eligible to receive child care services.

N.J.A.C. 10:15A-1.1(a)4 reflects current practice in the administration of the program. Added were references which require the county designated child care agency to ensure that families retrieved from the waiting list to receive services have remained eligible for the program. Also, additional language was added to replace previous references to vacancies in the program and the receipt of services when vacancies occur. In the operation of this child care service program, subsidies are made available when funds become available. Therefore, references to vacancies are inappropriate for a voucher subsidy system and have been removed.

N.J.A.C. 10:15A-1.1(a)5 is being deleted to reflect current practice in the program. This reference to duration of a family on the waiting list is inaccurate and was likely included as an assumption, prior to the adoption of the final Federal regulations, that practices parallel to some other DHS child care service programs would be paralleled in this program. When this provision was included, DFD had no pre-existing policy in this area to parallel. Upon implementation of the certificate program and the adoption of the final Federal regulations, it was discovered that this provision was not required, nor was it cost effective or feasible for inclusion in a voucher program due to limited administrative funds.

N.J.A.C. 10:15A-1.1(a)6 has been renumbered as N.J.A.C. 10:15A-1.1(a)5. N.J.A.C. 10:15A-1.1(a)5 and 5i also replace references to families being retained in child care with language which accurately depicts current practice. In this child care program, families may receive services for up to 12 consecutive months without a redetermination of eligibility.

N.J.A.C. 10:15A-1.1(b)3 replaces the term "protective service child" with the term "child protective services" which is now the terminology used by DYFS.

N.J.A.C. 10:15A-1.1(b)4 reflects Federal regulations at 45 CFR 98.20 and 257.30 which permit states to provide services to families where one parent is incapacitated.

N.J.A.C. 10:15A-1.1(d) provides clarification that the funding stream(s) for which a family is eligible, based upon the work, training, education, and/or protective service status of the family member, is indicated in parenthesis after the specific term. This subsection also clarifies the funding streams through which foster children and children under the supervision of DYFS may receive services. These proposed amendments are reflective of Federal regulations outlined in 45 CFR 98.20 and 257.30.

N.J.A.C. 10:15A-1.1(d)2 reflects current practice in the administration of the NJCK program regarding the selection of child care arrangements and the hours of care for which payment may be issued. In current practice, the parent/applicant selects and finalizes the child care arrangement for the eligible child and the payment issued on behalf of the family must be for hours which are reasonably related to the hours of the activity which deems the family eligible. This proposed amendment was made as a result of the requirements contained in the final Federal regulations governing these programs.

N.J.A.C. 10:15A-1.1(d)5 clarifies that funding must first be available prior to the receipt of services and that the funding stream(s) for which a family is eligible, based upon the work, training, education, and/or protective service status of the family member is indicated in parenthesis after the specific term.

N.J.A.C. 10:15A-1.1(e) includes an additional provision, under which refusal of child care benefits may be inferred, as required at 45 CFR 98.16(a)(7)(i) and 98.16(a)(11). As the program evolved it became increasingly apparent that parents/applicants were causing a delay on the part of the county designated agency in the determination of eligibility and the issuance of payment through a failure to return completed documentation on a timely basis. Also, as a result of the final Federal regulations, it is now a requirement in the Child Care and Development Block Grant State Plan to delineate the timeframe from the point of entry into the program to the point of eligibility and to provide a description of how the parent/applicant receives services. Therefore, it seemed appropriate to include the specific timeframes in the readoption of N.J.A.C. 10:15. The included provision increases the number of days a parent/applicant has to notify the county agency of their intent regarding: the receipt of child care services, to submit required eligibility information, to determine a family's child care needs, to select a child care provider, and to complete any other required documents to initiate payment. These proposed amendments are being included as a result of the adoption of the final Federal regulations. In this program, the receipt of benefits is contingent upon the completion of tasks by the parent/applicant within specified time frames. These time constraints have been included in the administration of this program so vouchers will be used in a timely manner by eligible families. Large numbers of families are eligible for this program and a limited amount of funding is available. To ensure the expedient receipt of services and the authorization of payment, families are required to complete specific procedures in a specified period of time or the receipt of services from this program may be jeopardized.

N.J.A.C. 10:15A-1.1(f) reflects current program practices regarding case and administrative reviews as previously described in N.J.A.C. 10:15-1.9(f)1i above.

N.J.A.C. 10:15A-1.1(f)2 and 3 provide an overview of the circumstances for continuation or termination of child care benefits in this program during the case and/or administrative review process. This child care service program is not an entitlement program; therefore, a parent/applicant receiving a service is not subject to the same guarantees as someone receiving services in an entitlement program. According to the Federal regulations governing these programs, the county designated child care agency must ensure that a parent/applicant receiving a service is eligible for such service (see 45 CFR 257.10 and 98.15) at all times. In addition, these paragraphs are being amended to replace all references to fair hearings, conducted by DFD, with references regarding the case and/or administrative review process. Finally, the reference to the hearing process for families receiving DYFS contracted child care services included in these sections provide a distinction between DYFS and DFD procedures.

N.J.A.C. 10:15A-1.2(b) reflects a change in the administration of the child care service program regarding the payments issued on behalf of school-age children. Due to limited funding and the vast amount of families eligible to receive services, an effort was made to provide services to as many families as possible with available resources. Therefore, parents of school-age children using before or after school care during the school year may receive only part-time payment for services during the school year, which represents the bulk of their expense. However, during the summer vacation periods only, these children may receive payment at the maximum allowable full-time rate. Parents of school-age children involved in non-traditional employment schedules when full-time child care is required on a year round basis, may continue to receive payment at the full-time rate.

N.J.A.C. 10:15A-1.2(e)1 corrects a typographical error and deletes the reference to protective service children. Protective services, as indicated previously, are not automatically eligible to receive benefits from this child care service program. There are specific eligibility criteria which must be met before a child in DYFS supervised CPS, including foster care children, may receive services. N.J.A.C. 10:15A-1.2(f)1 reiterates the different Federal eligibility criteria which are applied to ARCC and CCDBG.

N.J.A.C. 10:15A-1.2(g) provides clarification that the funding stream(s) (ARCC and/or CCDBG) for which a family is eligible, based upon the work, training, education, and/or protective service status of the family member, is indicated in parenthesis after the specific term. Also added is a provision which extends the authorization of bridge payments to families in the CCDBG program who end or no longer attend training or education activities. This addition was included as allowable pursuant to 45 CFR 98.20(a)3(ii). This subsection deletes a reference to the termination of a family, if the parent/applicant no longer complies with specific eligibility criteria without good cause. The interim Federal regulations for these programs were silent in this area. Therefore an assumption was made that the final Federal regulations would parallel the other Title IV-A programs administered by DFD. The adoption of the final Federal regulations for these programs identified only the required eligibility criteria to which parent/applicants must adhere. The final Federal regulations did not require the reason(s) for the ineligibility of a family to be identified and/or to become a factor of consideration in determining continued eligibility. Therefore all references to causes for non-compliance are no longer applicable. The term "protective services" children is being replaced with "CPS" and includes foster care children which is the accurate terminology now utilized by DYFS. Finally, this subsection is also being amended to reflect current operational practice regarding families who do not maintain their eligibility status. These families are not placed on the waiting list as previously stated in the original adoption of this chapter. Instead these families are terminated from the program and may reapply when they again become eligible. This proposed amendment is congruent with 45 CFR 98.20 and 257.30.

N.J.A.C. 10:15A-1.3(a) deletes a regulatory reference. The reference deleted is no longer applicable in accordance with the adoption of the final Federal CCDBG regulations.

N.J.A.C. 10:15A-1.3(b) includes reference to the DYFS Manual of Requirements for Child Care Centers which became effective on May 16, 1994.

N.J.A.C. 10:15A-1.3(b)1 and 2 include school-age children as part of the eligible population who can receive services from child care centers. This proposed amendment reflects the revisions set forth in N.J.A.C. 10:122, the DYFS Manual of Requirements for Child Care Centers.

N.J.A.C. 10:15A-1.3(d) deletes an inaccurate reference regarding family day care, pursuant to N.J.A.C. 10:81-14.18(f). As required by Federal regulation, providers of family-based day care are permitted to receive payment for such services if they live in the home of the child. This reference was included originally in error.

N.J.A.C. 10:15A-1.3(d)2 deletes an inaccurate reference, originally included in error, regarding the limitation on the number of children allowable in an approved home setting, pursuant to N.J.A.C. 10:81-14.18(f). This reference changes the maximum total number of children allowable in an approved home setting to eight, deletes the exception which previously permitted the maximum total number of children to increase beyond the allowable limit and permits all sibling children to receive care from the same approved home provider.

N.J.A.C. 10:15A-1.4(b) reflects current practice in the administration of the child care service programs made allowable through the adoption of the final Federal regulations. In a effort to reduce the amount of paperwork required of the county designated child care agency and of a parent/applicant, DFD now only requires the completion of the Parent/Applicant/Provider Agreement. This form replaces three previous documents. This subsection also clarifies the current practice regarding authorization of payment. The county designated child care agency, due to limited administrative funds, now verifies the attendance of a child in care by reviewing the voucher to determine that the parent and the child care provider have both attested to the attendance of the child through their signatures.

N.J.A.C. 10:15A-1.5(a), (d) and (e) change the terminology for "protective service" children to "children under DYFS CPS supervision and includes foster care children". These subsections also clarify the program eligibility for CPS children.

N.J.A.C. 10:15A-1.5(a) has also been recodified to facilitate the flow of information.

N.J.A.C. 10:15A-1.5(b) deletes an inaccurate reference regarding number of children in care and replaces it with the hours of care needed in specifying the determination of co-payment. This reference was originally included in error.

N.J.A.C. 10:15A-1.5(c) reflects current program practices regarding case and administrative reviews as previously described in N.J.A.C. 10:15-1.9(f)1i above.

N.J.A.C. 10:15A-1.5(d)1 adds the appropriate acronym for DYFS District Office and replaces a reference to "community referral agency" with "Adoption Resource Center". Reference to these agencies reflects current practice in the coordination of services in this program as determined by DYFS.

N.J.A.C. 10:15A-1.5(d)2 reflects current practice in the administration of the NJCK program. The appropriate DYFS agency is responsible to ensure that CPS and foster care children have alternative care arrangements prior to being terminated as deemed appropriate. This was not clear in the original regulations but has been clarified for this readoption.

N.J.A.C 10:15A-1.5(e) replaces the term "Regional Contract Administrator" with "DO/ARC Liaison." This proposed amendment reflects current practice in the program as defined by DYFS. This subsection is being amended to ensure all emergency terminations of CPS children are reported to DYFS.

At N.J.A.C. 10:15B, amendments are being made to N.J.A.C. 10:15B-1.1(c)4, 1.2(b), 1.2(h), 1.3(h), 2.1(a), 2.1(c), 2.1(d), 2.1(e)1, 2.2(a), 2.2(c) and 2.2(g) to reflect changes made as a result of the adoption of the final Federal CCDBG regulations and the Federal ARCC regulations regarding children in child protective services (CPS) under the supervision of DYFS who live in their own homes, as well as children in foster care.

The proposed amendments clarify the program eligibility criteria and co-payment requirements for both groups of children pursuant to 45 CFR 98.20, 98.42, 257.30(5) and 257.31. Families of CPS children under the supervision of DYFS who reside in their own home and are otherwise eligible, may receive service in both the ARCC and CCDBG programs. Children in foster care under the supervision of DYFS, if otherwise eligible, may receive services from the CCDBG program only. Both of these families are also permitted to have the assessed co-payment fee waived, but only on a case-by-case basis.

These sections are also being amended to clarify the program eligibility criteria regarding full-time employment and participation in full-time training and/or educational activities for ARCC and CCDBG. To remain eligible for the receipt of services in ARCC, a family must need child care services in order to obtain full-time employment within a specified period or maintain full-time employment. To be eligible in CCDBG, a family must need child care in order to accept full-time employment or full-time participation in training/educational activities or maintain full-time employment or full-time participation in training/educational activities, or to participate/enter into multiple part-time educational/training activities and employment which when combined equal full-time.

N.J.A.C. 10:15B-1.1(b), 1.1(c)4, 1.2(b) and 1.2(h) replace the term "protective services" children with the current terminology, "CPS" which also includes foster care children. This terminology has been developed by DYFS.

N.J.A.C. 10:15B-1.1(c)1 and 2 include references to the Division's Family Development Program (FDP).

N.J.A.C. 10:15B-1.2(b)1 updates the reference to the Federal Register publication in which the 1994 Federal Poverty Income Guidelines were published and clarifies the definition of low income families.

N.J.A.C. 10:15B-1.2(b)2 and 2i reflects the addition of income priority consideration for the entrance into the ARCC program. Final Federal regulations in ARCC permit State flexibility in the definition of low income (see 45 CFR 257.21(b)2). As a result, the Department of Human Services developed a broad definition of low income which permits additional families to receive services from this program as appropriate within the counties.

N.J.A.C. 10:15B-1.2(h) now includes an additional eligibility criteria in ARCC for families with one parent working and one parent incapacitated, which is permissible pursuant to 45 CFR 257.30(a).

Current N.J.A.C. 10:15B-1.2(h) has been recodified as N.J.A.C. 10:15B-1.2(i). N.J.A.C. 10:15B-1.2(i) clarifies that the final Federal regulations did not allow families under DYFS CPS supervision to have their co-payment waived in the ARCC program. In addition, Federal clarification prohibits children in DYFS supervised foster care to be served in the ARCC program.

N.J.A.C. 10:15B-2.1(a) and (c) reflect that families with moderate income levels (those up to 60 percent of the 1989 New Jersey State Median Income) are also eligible to receive services from the CCDBG program. This addition was made possible with DHS' adherence to the adoption of the final Federal regulations, pursuant to 45 CFR 98.20(a)(2).

N.J.A.C. 10:15B-2.1(d) includes special circumstances children as being given priority consideration and placement for CCDBG. This provision was made permissible with the adoption of the final Federal regulations, pursuant to 45 CFR 98.44.

N.J.A.C. 10:15B-2.1(d)1 and (e)3 reflect current practice in the administration of the CCDBG program regarding the definition of very low income, pursuant to 45 CFR 98.44.

N.J.A.C. 10:15B-2.1(e)2 includes the addition of the DHS administered School Based Youth Services Program (SBYS) and other teen parents as examples of those eligible for special circumstance consideration, pursuant to 45 CFR 98.44.

N.J.A.C. 10:15B-2.1(e)4 is being deleted as a priority consideration in this section. When DHS made the exit criteria for the ARCC program 75 percent of State Median Income, it eliminated the gap in program eligibility which existed between the income eligibility exit criteria for ARCC and income eligibility exit criteria for the CCDBG program. By allowing a family to stay in the ARCC funding stream with income above 185 percent of poverty, this revision eliminated a barrier toward uninterrupted service between the programs, pursuant to 45 CFR 98.1(a)8. It also ensured that more needy, lower income families would not be terminated from ARCC and be unable to enter into CCDBG because of the lack of funds.

N.J.A.C. 10:15B-2.2(h) provides an eligibility criteria in CCDBG which is permissible pursuant to 45 CFR 98.30. With this proposed amendment, a family where one parent who is working or participating full-time in a training/education program and the other parent who is incapacitated, may be served in the program.

At N.J.A.C. 10:15C, proposed amendments and/or additions are being made at N.J.A.C. 10:15C-1.1(a)1, 1.1(b)1, 1.1(b)3 and 1.4(c)6 to reflect

changes made as a result of the adoption of the final Federal CCDBG regulations and the Federal ARCC regulations regarding children in child protective services (CPS) under the supervision of DYFS who live in their own homes and children in foster care. The proposed amendments to these sections also clarify the program eligibility criteria and the co-payment requirements for both groups of children pursuant to 45 CFR 98.20 and 257.30(5).

Also, at N.J.A.C. 10:15C proposed amendments are being made at N.J.A.C. 10:15C-1.1(c), 1.1(g), 1.2(a), 1.2(b), 1.2(c), 1.2(c)1, 1.2(c)2, 1.2(c)3, 1.3(a), 1.3(a)3, 1.3(a)4 and 1.3(a)5 to provide clarification of current practice in the administration of the certificate program regarding the assessment and collection of the co-payment fees. With the adoption of the final Federal regulation for ARCC and CCDBG, states were permitted to simplify the co-payment assessment and collection requirements placed on families pursuant to 45 CFR 257.31 and 45 CFR 98.42. Therefore, these sections replace the required frequency of co-payment issuance from "weekly" to "monthly." The proposed amendments also reflect the manner in which the assessment of the required co-payment was simplified. This reference replaces the term "composite" co-payment to "total monthly" co-payment.

N.J.A.C. 10:15C-1.1(a)1 deletes an assurance that families receiving services for multiple DHS administered child care programs are not required to provide multiple co-payment fees to multiple child care providers and adds it as a new paragraph at N.J.A.C. 10:15C-1.1(a)2. This change was made to facilitate the flow of information contained in this section.

N.J.A.C. 10:15C-1.1(a)2 was added from N.J.A.C. 10:15C-1.1(a)1 to facilitate the flow of information. This provision ensures that families receiving services from multiple DHS administered child care programs are not required to provide multiple co-payment fees to multiple child care providers. This provision fosters the delivery of seamless child care services in New Jersey as recommended in the final Federal regulations.

N.J.A.C. 10:15C-1.1(c) reflects the program's current administrative practice made permissible with the adoption of the final Federal regulations regarding the family's issuance of a co-payment fee to child care providers. To ensure development of a flexible program which provides for the changing needs of families (45 CFR 98.1(a)5) a procedure was established which permits families to pay the entire assessed monthly co-payment fee to only one child care provider rendering services to the family. Such a provision helps to facilitate the program responsibilities of the parent/applicant.

N.J.A.C. 10:15C-1.1(d) revises an inaccurate reference regarding the determination of a family's co-payment. The number of children in the family was inaccurately included as a factor and the hours during which child care is needed was inaccurately omitted in the original adoption of this manual. This subsection also clarifies the period which is covered by the family's co-payment. In this child care program the co-payment is apportioned on a monthly basis instead of weekly as indicated.

N.J.A.C. 10:15C-1.1(e)1 adds the revised definition of family size for all families, including foster care families served in the CCDBG program, eligible to receive services from the ARCC and CCDBG program components.

N.J.A.C. 10:15C-1.1(e)2 corrects an inaccurate reference to subparagraph (e)1i. This reference was originally made in error, since this subparagraph was never included in this chapter.

N.J.A.C. 10:15C-1.1(f) reflects current administrative practice regarding the circumstances under which the assessed co-payment will change. These circumstances will include a change in family size, gross family income or a change in the care hours (full-time or part-time) needed by the family. This revision was made to adhere to requirements contained in the adoption of the final Federal regulations pursuant to 45 CFR 98.42. This subsection is also being amended to add the educational program enrollment of the parent as a factor requiring notification upon any changes. This factor was omitted in the original adoption and is a required eligibility criteria.

N.J.A.C. 10:15C-1.1(f)1 provides a provision regarding the determination of a co-payment for school-age children. Whenever there is a school-age child in a family, the county designated agency will determine a part-time co-payment for that child, unless the child is in full-time care for the entire 12 month eligibility period. This provision was added to ensure that the procedures developed for determination of co-payment would be supportive of the special needs of families with school-age children. The overall intent of this program is to provide assistance and support to families so that they can work, and/or remain in training or education. The current procedure requires families to report to the designated child care agency all changes effecting the determination of co-payment (change in family size, income, work, training/education status or hours of care needed as delineated in N.J.A.C. 10:15C-1.1(f)). The child care needs for families with school-age children frequently fluctuate during the school year between full-time and part-time due to regular school days, school holidays and vacation periods. As a result, the co-payment requirements of these families frequently change. Since families with school-age children would be required to comply with program procedures for reporting changes, they would be required to report changes affecting their co-payment fee amounts for frequent short or temporary changes. Such a procedure would not be supportive of families and does not reinforce the intent of the program. Therefore, a provision to assess a standard part-time monthly co-payment for the duration of the eligibility period for families with school-age children was determined to be the most beneficial procedure for both parents and the administration of the program. The alternative to this procedure for a standard monthly co-payment is to determine the child care needs (full-time and part-time) of each school-age child based on the period and/or day(s) as determined by regular school days, school holidays and/or vacation periods, for every school and/or public school district where an eligible child is enrolled. Administratively, this practice would be too cumbersome and too difficult for parents to keep track of the constantly changing co-payment amount required.

N.J.A.C. 10:15C-1.1(g) moves the reference regarding the coordination of services between all DHS child care programs to N.J.A.C. 10:15C-1.1(a)3. This reference ensures that the county designated agency will assess the appropriate co-payment fee when a family receives child care services from multiple Departmental child care programs. This reference was moved to facilitate the flow of information. N.J.A.C. 10:15C-1.3(a)6 adds an assurance that the delivery of services for all DHS child care programs is coordinated on all levels, as required by 45 CFR 98.1. This provision ensures that in instances where a family receives services from multiple DHS administered child care programs, the county designated agency will assess the co-payment fees appropriately and, in these instances, the monthly fees will be paid by the family to the child care provider receiving a subsidy on behalf of the eligible children in the voucher program.

N.J.A.C. 10:15C-1.3(c) replaces current language with a provision regarding the determination of a co-payment for school-age children. The county designated agency will determine a part-time co-payment for all school-age children, unless the child is in full-time care for the entire 12 month eligibility period. This provision was added to ensure that child care providers receive the appropriate co-payment for school-age children. Deleted from this section was a reference to rounding co-payment fees which is no longer a requirement, pursuant to the adoption of the final Federal regulations (see 45 CFR 98.42).

N.J.A.C. 10:15C-1.4(a) and 1.4(c)1 and 2 reflect the current administrative procedures, pursuant to the adoption of the final Federal regulations, regarding the collection, reporting and monitoring of the co-payment (see 45 CFR 98.42) in which the child care provider is responsible for collection and monitoring the receipt of co-payment fees and for reporting all instances of non-payment to the county designated agency. These proposed amendments are being made to ensure coordination of service delivery with the operational policies of existing child care providers. These proposed amendments satisfy required assurances set forth at 45 CFR 98.1(a)4 and 5.

N.J.A.C. 10:15C-1.4(a) deletes a reference to co-payment requirements for protective services children made inaccurate with the adoption of the final Federal regulations, 45 CFR 98.42(c).

N.J.A.C. 10:15C-1.4(c)1 deletes the term "child care service provider" and replace it with "child care provider" which is the current terminology.

N.J.A.C. 10:15C-1.4(c)3 through 7 reflect accurate terminology changes and provide updated information which reflects current practice in the administration of the program pertaining to rights of families affected by adverse actions in the delivery of child care service benefits through this program, such as termination for the failure to pay a required co-payment fee. Families that are affected by any adverse action to which they object, have the option to request a case review from the county designated child care agency and/or an administrative review from DFD. This procedure was initiated in the program effective September 1, 1992 because the child care service programs governed by these regulations are not entitlement programs such as AFDC, JOBS or Transitional Child Care. The ARCC and CCDBG programs are Federally funded and are based on specific eligibility criteria as set forth in Federal regulations (see 45 CFR 98.20 and 45 CFR 257.30). The Federal

eligibility criteria indicate that eligible parents enrolled in these child care programs do not have the same rights to the receipt of services as those parents receiving services in entitlement programs. The Child Care Service Manual was adopted with these now inaccurate references to DFD fair hearings practices set forth at N.J.A.C. 10:81-6, prior to the State receiving the final Federal CCDBG regulations.

N.J.A.C. 10:15 deletes references to "recipients," "applicant, "legal guardian" and/or "caretaker" and replaces them with "parent/applicant" were appropriate. In these child care service programs, the individuals making application for and those receiving services on behalf of eligible children are referred to as the parent/applicant.

Other amendments include technical updates, such as cross references and other technical corrections, which clarify rules and improve administration of the CCDBG and ARCC programs.

Social Impact

The CCDBG and ARCC programs first made available through OBRA 1990 are expected to have an overall continuously beneficial impact on low and moderate income families and child care providers. The funding received for these programs enables the State to continue provision of subsidized child care services to a needy population so that such families can remain employed or in the case of the CCDBG program, also attend educational or training programs. The funding continues to aid the State in offering child care services to some targeted categories of needy families who may not have been eligible to receive assistance with their child care costs in the past as a priority population. The State will continue to utilize a portion of the CCDBG funds to serve families with children involved in CPS, including foster care, under the supervision of the DYFS, who need child care services as required by the child's treatment plan.

Readoption of N.J.A.C. 10:15 will result in continuous, equitable determination of eligibility for all families. The absence of the rules contained herein would cause undue hardship to needy families eligible for the CCDBG and ARCC programs. Using December 1993 as an average month in which services were granted, DFD records indicate that 4,244 children eligible for CCDBG received assistance. In the ARCC certificate program during the same month, 4,096 children received services. The readoption is also essential for the efficient and effective administration of the CCDBG and ARCC programs by the contracted child care agencies.

The proposed amendments to subchapters 1 and 2 deal with updating the general provisions and the administrative responsibilities of the program which have occurred since the adoption of the manual in January 1992. The social impact of the rulemaking, experienced since the initial adoption, was favorable, since the amended sections improved upon the administration and operation of the program. The rulemaking facilitated the delivery and coordination of services provided to eligible families by the county child care agencies and DHS. No other significant social impact is expected at this time because families already enrolled in the programs will continue to be served.

N.J.A.C. 10:15A contains extensive proposed amendments which deal with general provisions pertinent to the operations of the CCDBG and ARCC programs. These proposed amendments are being included in the readoption to ensure compliance with the adoption of the final Federal regulations governing the programs. In a majority of the instances, the final Federal regulations enabled DHS to implement provisions which were least restrictive to the general population. The social impact realized by these amendments have had favorable results for the county designated child care agencies, parents, child care providers and DHS. These amendments have enabled all entities involved with this program to either administer or receive services in a more efficient and effective manner. No further social impact is expected from this rulemaking.

N.J.A.C. 10:15B is also being amended as a result of the adoption of the final Federal regulations. As a result, extensive changes were made to the eligibility criteria for children under the protective services supervision of DYFS, including foster care children. Also included, as a result of the adoption of the final Federal regulations, are provisions which expand the eligibility criteria to enable the county child care agencies to provide services to two parent families with one incapacitated parent who would otherwise be ineligible for services through this program. There are no further significant social impacts expected at this time.

The proposed amendments included at N.J.A.C. 10:15C deal with the co-payment fees required of eligible families in the CCDBG and ARCC programs. The proposed amendments reflect revisions since the initial adoption of this manual which have a favorable social impact on all entities involved in this program. Included in these amendments as a revision are provisions which facilitate the issuance of the fee so that parents are required to pay monthly fee to only one child care provider rendering services to the family. Also included are provisions which facilitate and coordinate the delivery of services between DHS administered child care programs for child care providers. The proposed amendments to this chapter will have a social impact which is favorable for parents and child care providers. No further significant social impact is expected.

Economic Impact

For the month of December, 1993, the total amount of service dollars issued on behalf of families eligible for CCDBG was $835,934 and for the families eligible for ARCC, the total amount of service dollars issued was $628,985.

The proposed amendments to N.J.A.C. 10:15A-1.2(b) and 10:15C-1.1(f)1 include a change in the operation of the child care services programs which will have an economic impact on the administration of the program. This change limits the payment for child care services to school-age children to the full-time maximum allowable rate only during the summer vacation period and/or when warranted by the work schedule of the parent/applicant.

However, in instances when the school-age child receives the part-time maximum allowable payment rate during the school year, the co-payment for this child is assessed at the part-time rate for the entire service period. The effects of this provision are that it maintains a standard payment rate for the county designated agencies and a standard co-payment requirement for the parents which enables the county designated agencies to more effectively and efficiently run the program. This results in savings which then allow the county designated agency to provide additional services to eligible families.

The effects of this provision are also of benefit to the parent/applicant, in that there is a positive economic impact and the amount of paperwork is significantly streamlined. For example, an average family of three with an income of $15,250 and one school-age child may realize an annual savings of approximately $75.00. This savings was calculated based on several variables. Taken into consideration were the estimated amount difference realized between the sum of the full-time and part-time co-payment fees for the appropriate amount of months (three months for summer and nine months for school-year) vs. the sum of a part-time co-payment fee at 12 months; the costs associated with the usage of a registered family day care provider for a part-time period during the school-year and a summer camp for a full-time period during the summer months; and the inclusion of an estimated 10 full days at the registered family day care rate for additional costs which the parent/applicant may incur for school holidays.

It is anticipated that no other significant economic impacts will be realized by the Department, the county child care agencies, child care providers or eligible families from the proposed amendments to N.J.A.C 10:15, 10:15A, 10:15B or 10:15C.

Readoption of N.J.A.C. 10:15 is essential for the efficient and effective administration of the CCDBG and ARCC programs by the county child care agencies. Failure to readopt this chapter will jeopardize receipt of program services for those eligible, could result in loss of Federal funds to the Department, leave the county designated child care agencies without proper guidance in the administration of this program and realize a significant loss of revenue to the contracted county designated child care agencies and to the community based child care providers, since the rules are essential for proper administration of the programs in accordance with the Federal regulations. The recipient families would also realize a negative economic impact in the failure to readopt this chapter. If ARCC eligible families did not continue to receive child care assistance from this program, they would immediately become at risk of losing employment and therefore become eligible for the AFDC program and thus lose their self-sufficiency. If assistance from the CCDBG program were unavailable, these families, while they are not quite as economically vulnerable as the families eligible for ARCC, may opt for less costly forms of child care or may not be able to retain employment or participation in their training/education activity.

Regulatory Flexibility Statement

These rules have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These rules and amendments impose no reporting, recordkeeping or other compliance requirements on small businesses. A regulatory flexibility analysis is not required,

inasmuch as these rules govern a child care service program, designed to provide assistance to low and moderate income families who are employed and/or participating in training or educational activities, administered by a governmental agency which contracts with county based child care agencies, rather than a private business establishment.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 10:15, 10:15A, 10:15B, 10:15C, as amended and supplemented by the New Jersey Register.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]).

10:15-1.1 Purpose and scope

(a) (No change.)

(b) The child care service programs, described herein, [are] **were** made available **originally** through block grant monies of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508. The block grant child care service programs are: The Aid to Families with Dependent Children (AFDC) At-Risk Child Care (ARCC) Program as implemented **originally** by Section 5081 of OBRA 1990; and the Child Care and Development Block Grant (CCDBG) Act of 1990 as implemented **originally** by Section 5082 of OBRA 1990. **Through the original and subsequent allocations,** [Those] funds are offered by the Administration of Children and Families (ACF), U.S. Department of Health and Human Services, to states with approved State Plans to increase the availability, affordability, and quality of child care.

(c) The AFDC At-Risk Program (also known as IV-A At-Risk Program) and the CCDBG eligibility requirements, specific for each of those funding streams, are described at N.J.A.C. 15B-1 and 10:15B-2 respectively. DHS shall operate these child care service programs through the coordination efforts of [its Office of Child Care Development in conjunction with existing Departmental programs available through] its Divisions of Youth and Family Services (DYFS) and Family Development (DFD), as described in rules set forth at N.J.A.C. 10:81 and 10:82. The policy provisions and terms in this chapter are general provisions which are applicable throughout all chapters N.J.A.C. 10:15A, 10:15B and 10:15C on child care services through the Department of Human Services.

1.-2. (No change.)

(d) New Jersey has the opportunity to expand, improve and develop child care services for the families of this State. A primary objective of the New Jersey Department of Human Services (NJDHS) is to offer families comprehensive child care services that will enable them to secure or maintain employment and thus become self-sufficient from public assistance benefit programs. Additionally, both the IV-A "At-Risk" and the CCDBG programs emphasize the availability of child care services for families **under DYFS' Child Protective Services (CPS) supervision. For families** serving as substitute care settings for protective services children **(foster care)** identified by DYFS, **the CCDBG program emphasizes the availability of child care services**. Such families must satisfy the eligibility criteria for those programs. Based on its extensive experience in child care and early education programs, the Department of Human Services sets forth the following principles for a comprehensive [child care] delivery system of child care services in the State.

1.-10 (No change.)

11. The Department promotes the development of employer-supported child care. DYFS[, in conjunction with the Department's Office of Child Care Development, continues to work with the Department of Community Affairs' Division on Women and the New Jersey Task Force on Employer-Supported Child Care in directing a program of information-sharing and technical assistance to promote the creation and expansion of employer-supported child care resources] **provides technical assistance and consultation services to public/private/volunteer advocacy organizations seeking to promote employer-supported child care services throughout the State.**

(e) Nothing in these rules shall be construed as conferring on [an applicant or recipient of] **a parent/applicant receiving** child care services an entitlement to those services. If the fiscal or other resources necessary for child care service provision to [an applicant/recipient] **a parent/applicant** are unavailable, that individual shall not be deemed to have a right to such services and the individual and the county designated agency shall be released from all obligations for those services under these rules.

(f) (No change.)

(g) Each county shall coordinate child care service programs with units of local government; existing child care resource and referral agencies; with early childhood education programs in the county, including Head Start programs; preschool programs funded under Chapter 1 of the Education Consolidation and Improvement Act of 1981 (public Law 97-35); school and nonprofit child care programs (including community-based organizations receiving funds designated for preschool programs for [handicapped] **disabled** children); with organizations sponsoring before-and-after school activities; with the REACH/JOBS/**FDP** program; DYFS contracted centers; private providers; sectarian providers; and with Federal and/or State demonstration programs, such as the [Urban Pre-Kindergarten Pilot] **Goodstarts** program, the REACH/JOBS Capital Expansion Program, and the Mini-Child Care Center program.

10:15-1.2 Definitions

The following words and terms, when used in this chapter and N.J.A.C. 10:15A, 10:15B and 10:15C, shall have the following meanings, unless the context clearly indicates otherwise.

"Approved home" means a family day care provider not registered pursuant to the Family Day Care Provider Registration Act (see N.J.A.C. 10:126), whose home has been evaluated and [which has passed a health and safety check to qualify] **authorized** for payment through the Department's child care service programs**, using the Self-Arranged Care Inspection and Interview Checklist (see N.J.A.C. 10:15A, Appendix B)**. Such providers may receive payment for a maximum of two nonsibling children, or all the sibling children of one family so long as the total number of children in the provider's care does not exceed [seven] **eight** children[; and, the number of sibling children for whom payment is made does not exceed five].

...

"Categories of care" means licensed center-based care, **school-age child care programs,** registered family day care, approved home care, in-home care, before-and/or after-school care, and summer camp.

...

"Child care center" means any home or facility, by whatever name known, which is maintained for the care, development or supervision of six or more children under [six] **13** years of age who attend for less than 24 hours a day.

"Child Protective Services (CPS)," formerly known as Protective Services, means services on behalf of any child, under age 18, considered at risk of abuse, neglect, or exploitation; or found to be abused, neglected, exploited or abandoned, as identified by DYFS. The term, unless otherwise specified, includes services provided to children in out-of-home settings, such as foster care.

"Co-payment" means a portion of the family income that is paid by the eligible family toward the cost of child care. The amount of the required co-payment is based on the family's annual gross income level, family size, **hours of care needed,** and number of children in care.

...

"Foster care" means DYFS approved out of home placement services designed to provide a substitute family for a child who needs care outside his or her home for a temporary or extended period of time, as part of a child protective services (CPS) case management plan. The DYFS foster care program also includes services provided to CPS children in para-foster care, children under the guardianship of DYFS and children surrendered to DYFS.

"Incapacitated parent" means a parent/applicant who has a permanent physical or mental defect, illness or impairment which is supported by medical evidence and/or recorded testimony of a licensed medical health care professional, and which must be of such a debilitating nature as to reduce substantially or eliminate his or her ability to care for the eligible child(ren).

...

"New Jersey Cares for Kids (NJCK) Child Care Certificate Program" means the child care certificate program funded primarily

by the IV-A "At-Risk" and the CCDBG grants. Also known as the NJCK Program or the Certificate Program.

["OCCD" means the Office of Child Care Development in the New Jersey Department of Human Services.]

...

"Parent/applicant" means an individual who has applied for and/or receives assistance with child care services, on behalf of an eligible child, from the Title IV-A "At Risk" program or the Child Care Development and Block Grant Program.

"Protective services" [means services on behalf of any child, under age 18, considered at risk of abuse, neglect, or exploitation; or found to be abused, neglected, exploited or abandoned and whose conditions or situation gives observable evidence of the injurious effects of failure on the part of parents or others responsible for meeting at least the minimum needs of the child, as identified by DYFS. The term includes services provided to children in their own home, in foster care, children in para-foster care, children in pre-adoptive homes, children under the guardianship of DYFS, and children surrendered to DYFS] **(see Child Protective Services and/or Foster Care)**.

...

"Special circumstances child" means a child that is not under Division of Youth and Family Services CPS supervision who has been identified through a written referral from a county welfare agency, DYFS, legal, medical, social service agency, emergency shelter, public school or School Based Youth Services Program which indicates that the child is from a family experiencing medical or social problems or adverse living conditions and child care arrangements are required to help ameliorate the situation and/or prevent the placement of the child or other family member(s) outside the home. Children of teen parents are also considered a special circumstance.

10:15-1.4 Atmosphere of mutual respect

(a) Assistance and services through the child care service programs shall be rendered to all [applicants/recipients] **parents/applicants** in an atmosphere of mutual respect between county designated agency employees and the families they serve.

(b) (No change.)

10:15-1.5 Nondiscrimination

There shall be no discrimination on grounds of race; color; religious affiliation; sex; national origin; ethnic background; marital, parental or birth status; or [handicap] **disability** by the Department, its [Offices and] Divisions or the county designated agencies in the administration of the child care service programs.

10:15-1.6 Confidential nature of information

(a) Information about [applicants or recipients] **parents/applicants** for child care service programs shall be used and disclosed only for the purposes directly connected with the administration of child care service programs**, or for CPS children as permitted by N.J.S.A. 9:6-8.10a**.

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

10:15-1.7 Primary source of information

(a) [Applicants and recipients] **Parents/applicants** of child care service program benefits are in all instances the primary source of information about themselves and their families.

(b) It is the responsibility of the county designated agency to determine eligibility based on the information provided by the [applicant/recipient] **parent/applicant** and, as necessary, to secure verification from secondary sources. Such verification shall be limited to those facts which are essential to establish eligibility and shall be obtained only with the known consent of the [applicant/recipient] **parent/applicant**.

(c) The county designated agency worker shall explain to the [applicant/recipient] **parent/applicant** that verification is necessary and that lack of consent on behalf of the [applicant/recipient] **parent/applicant** to obtain the necessary verification shall make processing of the application/reapplication impossible.

10:15-1.9 Issuance and availability of manual

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

(d) The director of the county designated agency shall make available copies of this manual to all staff members working with [applicants and recipients] **parents/applicants** of child care service programs. Likewise, all updates to manuals shall also be issued to staff. The county designated agency has the responsibility and shall ensure that each staff member working with these service programs is thoroughly familiar with the manual's contents, and applies the required policy and procedures consistently.

(e) (No change.)

(f) This manual is a public document. It is important that all copies in use be up-to-date. It is available as follows:

1. Copies are available for examination or review during regular office hours on regular work days in the Department of Human Services[, Office of Child Care Development]; in the Divisions of Family Development and Youth and Family Services; and in each county, at the office of the county designated agency.

i. Specific policy material necessary for [an applicant or recipient] **a parent/applicant** or his or her representative to determine the basis for a [fair hearing] **case or administrative review** request, or to prepare for a [hearing] **review**, shall be provided to such persons without charge.

2.-5. (No change.)

6. Employment, education and training organizations (that is vocational/technical school, community colleges, JTPA offices) shall be furnished with a copy of this manual **through written request to DFD**.

7.-8. (No change.)

10:15-2.1 Department of Human Services responsibilities in child care service programs

(a) The Department of Human Services (DHS) is the lead State agency responsible for child care service program delivery in the State. DHS, through its [Office for Child Care Development] **Divisions of Family Development and Youth and Family Services**, shall coordinate and supervise the administration of the Child Care and Development Block Grant (CCDBG) and IV-A "At Risk" (ARCC) programs[, by its Divisions of Youth and Family Services and Family Development].

(b)-(j) (No change.)

(k) For activities to improve the quality of child care, DHS shall enter into purchase of service contracts and/or grants with eligible entities through the competitive State process (request for proposal) **or continuation funding**. DHS [plans to invest] **invests** in:

1.-2. (No change.)

3. Training and technical assistance to child care providers in areas such as, but not limited to, parental choice, management and early childhood development; [and]

4. To increase the availability of early childhood development programs and to increase the availability of before- and after-school care services[.]**; and**

5. To increase the availability of child care resources for teen parents.

6. To provide consultation and referral services to parents.

10:15-2.2 Divisional responsibilities

(a) The Division of Family Development shall be responsible for the following activities in the administration of DHS child care service programs.

1. (No change.)

2. The **contract, programmatic and fiscal** supervision of the certificate system with the 21 community based organizations **or county government offices** which will [be] administer[ing] the certificate program at the county level;

3. (No change.)

4. Providing for [an] **a case/administrative review** appeals process through Divisional proceedings when situations concerning certificate [applicants and/or recipients] **parents/applicants** are not resolved at the level of the local county designated agency [in accordance with N.J.A.C. 10:81-6];

5. Submission of required reports to the Federal Administration for Children and Families on the IV-A "At-Risk" and CCDBG child care programs; [and]

6. Issuance of and updates to the manual, and maintenance of a current mailing list for dissemination of manual revisions[.]; **and**

7. Periodically conducting a local market survey of child care costs for the various types of child care arrangements for full or part-time care.

(b) The Division of Youth and Family Services has responsibility for the following types of activities in the child care service programs:

1. (No change.)

2. Collaboration with the Division of [Economic Assistance] **Family Development** in the development of policies and procedures for the child care service programs; [and]

3. [Periodically conducting a local market survey of child care costs for the various types of child care arrangements and full or part time care to ensure that the Department's rates for child care services are competitive with rates for unsubsidized care to ensure the continued availability of child care services for child care service program recipients.] **The administration and supervision of the ARCC related purchase of service contracts with child care providers.**

4. The administration and supervision of contracts which are established with CCDBG funds set aside to establish, expand or conduct early childhood development and/or school-age child care programs and to improve the quality and availability of child care.

10:15-2.3 County designated agency responsibilities

(a) Each county designated agency shall:

1.-13. (No change.)

14. Issue [certificates] **the appropriate forms and materials** to eligible [applicants/recipients] **parents/applicants** for receipt of provider services;

15. (No change.)

16. Provide for due process for [applicant/recipient] **parent/applicant** complaints and provider concerns. Issues not resolved at the local county agency level may be taken to the Divisional level **for a case/administrative review** [(N.J.A.C. 10:6)];

17. Establish written agreements for services among the county designated agency, the [recipient] **parent/applicant**, and the provider regarding agreed-upon arrangements, co-payment responsibilities, and the submission of vouchers for payment of service;

18. Determine payment to provider(s) from the program and the amount of the co-payment paid by the [applicant/recipient] **parent/applicant**;

19. Establish [a written] **an** agreement between the county designated agency and the DYFS District Office in the county for [protective service] children **in child protective services under DYFS supervision including children in foster care under the supervision of DYFS.**

20.-21. (No change.)

22. [Verify] **Review the** [children's] attendance **forms and certify them for payment, for children** in the care of providers participating in the child care service programs;

23. Provide information on the certificate program operation to [applicants/recipients] **parents/applicants** and the community;

24.-31. (No change.)

10:15-2.4 Provider responsibilities

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

(c) The provider shall complete vouchers with child(ren)'s attendance data [and co-payment information], obtain[s] the [caretaker's] **parent's/applicant's** signature and send vouchers to the county designated agency within three business days of closing of reporting payment periods.

(d) (No change.)

(e) The provider shall ensure that no other public subsidy is received for the same period for the eligible children.

(f) The provider shall return all overpayments to the county designated child care agency.

(g) The provider shall provide 10 day notice to parents/applicants and to the county designated agency when a child will be terminated.

(h) The provider shall comply at all times with regulatory requirements for licensure of child care centers, registration of family day care homes or the authorization of approved homes as appropriate and as defined in N.J.A.C. 10:15-1.2.

10:15-2.5 [Applicant or recipient] **Parent/applicant** responsibilities

(a) The [applicant or recipient] **parent/applicant** shall:

1.-6. (No change.)

7. Be responsible for all child care provider costs in excess of the maximum allowable payment for which they are eligible as indicated in N.J.A.C. 10:15A-1.2(c).

8. Comply at all times with the program eligibility requirements, pertaining to employment, training, education or child protective service status, and income eligibility requirements while in receipt of services (see N.J.A.C. 10:15A, 15B, 15C).

10:15A-1.1 Child Care Service Program availability

(a) **As funding and Federal criteria permit, and to** [To] the extent that such child care is necessary to permit an **ARCC** eligible family member to accept employment or to remain employed, or to **permit a CCDBG eligible family to obtain or** participate in work/training or educational activities, child care service benefits are available based on the individual needs of each family. Additionally, child care services are also available for [protective services children identified] **children under DYFS child protective services (CPS) supervision including children in foster care also supervised** by DYFS, if child care services are necessary as part of the child's treatment plan [, and for protective services children in substitute care settings under the custody of DYFS]. Payments through the child care service programs for child care shall not be made for care provided by the child's own parents, legal guardians, or members of the [applicant's] **child's** family unit, on the basis of their responsibility of caring for their own child(ren). Child care service programs include the IV-A "At-Risk" Program (see N.J.A.C. 10:15B-1) and the Child Care and Development Block Grant (CCDBG) Program (see N.J.A.C. 10:15B-2). [Other child care service programs offered through DHS are set forth at 10:81-4.18.]

1.-2. (No change.)

3. The waiting list shall be kept by the county designated agency according to the dates the application was received by the agency **and the family was determined to be eligible to receive services from the program,** [and] by priority group status (see N.J.A.C. 10:15B-1.1(c) [and], 2.1(e)), **and by the family's annual gross income level (see N.J.A.C. 10:15B-1.2(b) and 2.2(b)).**

4. The waiting list shall be reviewed and waiting list families re-evaluated for service when resources are available. If the family who is next on the waiting list **remains eligible and** is unable to utilize the [vacancy] **subsidy** when it [occurs] **becomes available,** the agency proceeds to the next family on the list.

[5. Names shall be retained on the list for one year. At the end of the year, the family is to be contacted (if not contacted previously) to make a new application for services if still interested and if in need of child care.]

[6.]**5.** Families found eligible to participate who are provided ARCC or CCDBG services shall [be retained in child care] **receive a child care subsidy** for up to 12 consecutive months **without a redetermination of eligibility** if the need for the service remains, the program eligibility criteria are met, and resources remain available.

i. A child shall not [be retained in child care] **continue to receive a subsidy** if the need for service no longer exists.

ii. An exception may be made in the **CCDBG program in the** case of loss of employment **or for non-participation in a training/education activity** by the parent/**applicant**. In such situations, the child(ren) may be continued in child care for a period not to exceed one month, [if] **so** the parent [can demonstrate to the agency that he or she is] **may** actively seek[ing] employment. **If the parent/applicant fails to obtain employment and/or begin participation in a training/education program at the end of the one month period, then the family is no longer eligible to receive child care services**

from this program. In the ARCC program, after loss of employment, child care may be continued for up to one month if new employment, scheduled to begin by the end of the month, is secured.

(b) To be eligible for services through the child care services programs, a child must:

1.-2. (No change.)

3. Be under the **child protective services** supervision of DYFS [(that is, protective service child).]; **or**

4. Reside with a family where one parent is working (ARCC and CCDBG) or attending a training/education program (CCDBG only) and the other parent is incapacitated as set forth in N.J.A.C 10:15-1.2.

(c) (No change.)

(d) The parent/**applicant** and the county designated agency, upon request of the **parent/**applicant, will mutually arrange for child care for the parent/**applicant's** child(ren) while the individual is employed full-time (**ARCC and CCDBG**) or participating in full-time educational or work/training activity (**CCDBG only**), or for a [protective services child] **DYFS supervised foster care child (CCDBG only) or for** [identified by DYFS as set forth in the application for child care services.] **children under the child protective services of DYFS, who reside with their natural parent(s) (ARCC and CCDBG).** Parental choice from among categories of care or types of providers is guaranteed to the extent practicable under Federal and State laws and regulations.

1. Child care arrangements shall be in the best interests of the child and parent/**applicant** [or legal guardian] and shall consider the individual needs of the child, including the reasonable accessibility of the care to the child's home and school, and the appropriateness of the care to the age and special needs of the child.

2. Child care arrangements shall be [agreeable to the parent (to the maximum extent possible) The] **selected and finalized by the parent/applicant. When selecting a child care provider the parent/applicant shall be informed that the** hours **of care for which the program will issue payment** [provided or claimed for reimbursement] shall be reasonably related to the hours of participation in the education/training activity (**CCDBG**) or employment (**CCDBG and ARCC) as indicated by the parent/applicant** [and shall be sufficient to accommodate the hours required by the employer or the activity].

3.-4. (No change.)

5. [Child] **To the extent that fiscal or other resources necessary for child care provision are available, child** care is available to the extent that child care is necessary to permit a member of the family to accept or retain full-time employment (**ARCC**) or to participate in full-time educational or work/training activities (**CCDBG only**) if the family meets **the** income eligibility level; and **in the CCDBG program** for [protective services] children **under the child protective services supervision of DYFS, including children in foster care,** needing child care as part of the child's treatment plan [or when such children are in substitute care setting under the custody of DYFS and to the extent that fiscal or other resources necessary for child care provision are available].

(e) Refusal of child care benefits may be inferred if the applicant does not select a child care provider **or notify the county designated agency of their need for child care referral services** within [10] **15** calendar days of the date the [participant and the] county designated agency [evaluate the participant's child care needs and preference of providers and made referral(s) to appropriate child care provider(s)]; **informs the family that they are eligible for services through these child care programs fails to select a child care provider after the receipt of child care referrals or fails to notify the county designated agency of the need for additional child care provider referrals;** does not provide the information necessary for determining eligibility and co-payment amount **within the timeframe specified by the county designated agency,** including verification of earnings; does not sign **and/or return** the **completed Parent/Applicant/Provider** Agreement for the receipt of care; [or] does not co-sign the child care voucher; **or fails to comply with any other program eligibility requirement of N.J.A.C. 10:15, 10:15A, 10:15B or 10:15C.**

1-3. (No change.)

(f) [Applicants and recipients] **Parents/applicants** of child care service programs are entitled to [hearings] **a case review conducted by the county designated agency and/or an administrative review conducted by DFD** and notices through the county designated agency on issues concerning the appropriateness of, denial of, prompt issuance of, or intended actions to terminate or reduce child care benefits.

1. (No change.)

2.If the individual [had] **has** been receiving child care benefits and is awaiting a [hearing] **review** concerning those benefits because such benefits were reduced, he or she is not entitled to receive child care benefits at the prior unreduced level. Benefits shall continue at the determined reduced level pending the [hearing] **review.** If the individual had not been receiving any child care benefits and is awaiting a [hearing] **review** due to nonreceipt of child care benefits, he or she is not entitled to receive any child care benefits pending the [hearing] **review. If the individual had been receiving child care benefits and is awaiting a review concerning those benefits because such benefits were terminated, he or she is not entitled to receive child care benefits pending the review.**

3. If a particular issue is not resolved at the county agency level, [a hearing shall be provided in accordance with N.J.A.C. 10:81-6] **an administrative case review to be conducted by DFD may be requested** for those participants receiving care through the certificate [(voucher) process] **program** or **a hearing shall be provided** through DYFS for **those participants receiving care through** contracted child care services [(]**in accordance with** N.J.A.C. 10:120-3[)].

10:15A-1.2 Payment policies

(a) (No change.)

(b) Payment for care of school-aged children[, which is normally limited to part-time or after school care during the school year,] shall **continue to** be made at the [full] **part-**time rate during [summer vacations and] recognized vacations and holidays during the school year, for example, Christmas, spring vacation, and so forth**, unless the parent/applicant requires full time care year round due to their work schedule. Payment for the care of school-aged children attending care full-time during summer vacation periods shall be made at the full-time rate.**

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

(e) The following conditions must be met for receipt of child care service program benefits:

1. The [applicant] **parent/applicant** shall request child care benefits and provide the information necessary, including verification of earnings, for determining eligibility and co-payment and the family meets the financial eligibility requirements for either the IV-A "[at] **A**t-Risk" program or the CCDBG program as set forth at N.J.A.C. 10:15B-1 and N.J.A.C. 10:15B-2[, respectively, or the child is a protective services child].

2. The [applicant] **parent/applicant** shall sign an agreement covering the period during which the child care is to be provided;

3. The [applicant] **parent/applicant** shall select a provider as set forth in the agreement;

4. The [recipient] **parent/applicant** shall pay the required co-payment (see N.J.A.C. 10:15C-1.1(a)1 for the exception to co-payment) to the provider of care; and

5. The [recipient] **parent/applicant** shall report changes in circumstances to the county designated agency.

(f) The family is not eligible for child care for any remaining portion of the 12 month period if the [caretaker] **parent/applicant**:

1. Terminates full-time employment (**ARCC and CCDBG**) or training or educational programs (**CCDBG only**) [without good cause], or the wages/income exceed eligibility levels;

2.-3. (No change.)

(g) [If] **Contingent upon compliance with applicable Federal eligibility criteria unique to ARCC and CCDBG as set forth in N.J.A.C. 10:15B-1 and N.J.A.C. 10:15B-2, if** the [caretaker] **parent/applicant** loses a job **(ARCC and CCDBG) and/or ends or no longer attends their training/education activity (CCDBG only)** and [with good cause, and] then begins employment **and/or another training/education activity (CCDBG only)** within one month of the loss of

the previous job[,] **and/or training/education activity,** the family can qualify for the one month of care during the transition between jobs, **and/or training/education activities (CCDBG only)**, as well as for the remaining portion of up to 12 months in the child care eligibility period. [However, child care service benefits shall be terminated and eligibility shall not be reestablished if the recipient loses a job without good cause, or does not attend or stops participation without good cause in education or work/training activities.] ([Protective services] **CPS and foster care** children shall be treated in accordance with N.J.A.C. 10:15A-1.5(d).) [That individual shall be placed on the waiting list for services.] **If the individual becomes eligible again, he or she must reapply.**

10:15A-1.3 Provider requirements

(a) Payments to providers of child care through child care service programs are available according to the [following conditions and are in accordance with existing payment procedures for child care providers set forth at N.J.A.C. 10:81-14.18] **requirements of this section.**

(b) To qualify for child care payments, a child care center or program shall meet one of the following requirements as set forth at N.J.A.C. 10:122-**2**, Manual of Requirements for Child Care Centers, (N.J.S.A 30:5B-1 through 15); (see also N.J.A.C. 10:81-14.18(f)1):

1. Centers providing care for infant, [and] preschool **and school-age children up to the age of 13 years,** shall be licensed by DYFS, Bureau of Licensing or shall have a letter of exemption from DYFS, Bureau of Licensing;

2. [Child] **Until such time as the Division of Youth and Family Services' licensing regulations for this type of care are implemented, the** child care programs for school-age children shall meet local occupancy building and fire codes and shall have satisfactorily completed an inspection using the DHS' "School-Age Child Care Interim Guidelines Checklist" (see Appendix A, incorporated herein by reference); or shall be operated under the auspices of the public school system or a DYFS contract; or

3. (No change.)

(c) (No change.)

(d) Providers of family day care [who are not living in the home of the child care applicant/recipient and] who are not registered under (c) above shall be approved by the Department of Human Services in order to qualify for payment through any child care service program. Unregulated relatives, friends or neighbors are eligible for approved home status.

1. (No change.)

2. As an approved home, providers may receive payment for a maximum of two nonsibling children or [of] **for** all the sibling children of one family so long as the total number of children in the home does not exceed [seven] **eight** children[, five of which are for payment purposes; and, the number of sibling children for whom payment is made does not exceed five].

(e)-(f) (No change.)

10:15A-1.4 Payment methods

(a) (No change.)

(b) Vendor payments to providers are the primary method for issuing child care payments in the child care service programs. Under this method, a voucher is issued to the child care provider after the completion and signing of a [provider agreement] **Parent/Applicant/Provider Agreement. The completion of this agreement permits the provider to receive an initial prospective monthly payment. To receive subsequent payments, the** [The] provider completes the voucher form, lists the dates of care, signs the voucher, secures the parent's signature and returns it to the agency responsible for issuing payment. Upon [verification] **review and authorization** of the voucher information, the agency issues a child care payment to the provider.

(c) (No change.)

10:15A-1.5 Requirement of co-payment

(a) Each family receiving child care is required to contribute a co-payment toward the cost of such care.

1. The exception to the co-payment requirement applies to **children under child** protective services **supervision** [child(ren)] as identified by DYFS (see N.J.A.C. 10:15-1.2) **including those** living in a substitute care setting under the custody of DYFS **in the CCDBG program. The co-payment for CPS children may be waived in CCDBG on a case by case basis; such a waiver is granted by the DYFS District Office (DO). The standards used by DYFS will incorporate, but not necessarily be limited to situations where:**

i. A parent refuses to pay, is uncooperative in providing income information, or is otherwise uncooperative with the treatment of plan of the child; or

ii. There is a court order prohibiting or limiting parental involvement with the child; or

iii. One parent in a two parent family cannot be located; or

iv. The parent is unable to pay and to require the parent to pay will place the family at risk of homelessness; or

v. The parent is unwilling or unable to pay, and to pursue payment would place the child, the siblings or the case plan in jeopardy.

2. Additionally, no co-payment is required for purposes of other Departmental child care programs if the family has children in care through the CCDBG or IV-A At-Risk programs and the family is making a co-payment for two children under either of these child care program requirements.

(b) A co-payment scale established by the Department of Human Services will provide for some level of contribution by most [recipients of] **parent/applicants receiving** child care. The co-payment scale shall consider: family income, family size, [number of children], **hours of care needed,** and number of children in care. The co-payment scale is set forth at N.J.A.C. 10:15C-1.1(d).

(c) Individuals who fail to cooperate in paying the required co-payment will, subject to appropriate notice **requirements** and [hearing requirements], **if requested, a case or an administrative review as set forth at N.J.A.C. 10:15A-1.1(f),** lose eligibility for child care benefits for so long as back co-payments are owed, unless satisfactory arrangements are made with each provider to make full payment of arrearages.

(d) [Children] **In the CCDBG program, children** under **the child protective services (CPS) supervision of** DYFS [supervision and placed with a caretaker family] **, including foster care children,** shall not be terminated from services until:

1. The referring DYFS District Office **(DO)** or [community referral agency] **Adoption Resource Center (ARC)** has been notified;

2. [Alternate] **The referring DO and/or ARC maintains the responsibility for making alternate** child care arrangements [have been made] **as deemed appropriate; and**

3. (No change.)

(e) [Any] **In the CCDBG program, any** emergency termination of service initiated by a child care provider of a [protective services] **DYFS CPS child, including foster care,** [for reasons other than loss of financial eligibility or failure to comply with other rules or contractual provisions] shall be reported to the DYFS [Regional Contract Administrator] **DO/ARC Liaison.**

10:15B-1.1 Description of IV-A "At-Risk" Program

(a) (No change.)

(b) Child care assistance is also available to a [protective service] child **who is under the child protective services of DYFS and** who resides [with a family] **in their own home with their parents** whose income meets the definition of low income as set forth in N.J.A.C. 10:15B-1.2(b).

(c) Services shall be provided to the extent of the State's entitlement to Federal monies, by targeting those most "at risk" of becoming AFDC-dependent. Groups identified as most "at risk" for participation include:

1. Families who are former AFDC recipients and who have completed their 12-months of REACH/JOBS/**FDP** transitional child care eligibility (see N.J.A.C. 10:81-14.18);

2. Families who are ineligible for Federal REACH/JOBS/**FDP** transitional child care benefits;

3. (No change.)

4. Families who have children identified as being in need of **child** protective services **(excluding foster care children) under CPS supervision of DYFS**; or, who are at risk of becoming homeless; or,

who are teen parents (not on AFDC) who are employed and otherwise eligible for IV-A "At Risk" assistance.

10:15B-1.2 Eligibility for IV-A "At Risk" Child Care (ARCC) Program

(a) (No change.)

(b) Families shall be working low-income families or a working low income family that has a [protective services] child in [need of] child [care] **protective** services [residing] **under the supervision of DYFS and who resides** in the family's home.

1. ["Low] **For program entrance "low** income" families are defined for purposes of this program as families whose gross annual income for the family size is at or below 200 percent of the Federal Poverty Income Guidelines published annually in the Federal Register (reference the Federal Register, Vol. [57] **59**, No. [31] **28**, dated February [14] **10**, [1992] **1994**, page [5455] **6277**). Subsequent updates to these Guidelines in the Federal Register will be published as a public notice by the Department in the New Jersey Register.

2. The annual gross income of the family must fall at or below 200 percent of the Federal Poverty Income Guidelines for the family size to establish **initial** income eligibility.

i. Priority attention shall be given to those families at the lower end of the income spectrum, that is, **those** at or below 150 **percent of poverty will be given highest priority and those at 175** percent of poverty **will be given the next highest priority**.

3. [Recipient families] **Families** may remain eligible under the IV-A At-Risk Program as long as the family's annual gross income, for the family size, does not exceed 75 percent of the State's median income (SMI) for a family of the same size. (The SMI for states is published by the Federal Administration for Children and Families in the Federal Register. The SMI was last published in the Federal Register, Vol. No. 53, No. 64, April 4, 1988. Subsequent updates to the SMI will be published as a public notice by the Department in the New Jersey Register.)

(c)-(g) (No change.)

(h) An eligible family shall be a two parent family where one parent who is working and the other is incapacitated, as defined in N.J.A.C. 10:15-1.2.

[h](i) Families shall make a co-payment toward the cost of care in accordance with N.J.A.C. 10:15C. The exception to the copayment requirement exists when the child is identified as [a] **under the** protective services [child by] **supervision of** DYFS as defined at N.J.A.C. 10:15-1.2. [Who is living in a substitute care setting under the custody of DYFS. No co-payment is determined for such children (see also N.J.A.C. 10:15C-1.1).] **A co-payment will be assessed for such children but may be waived on a case by case basis by the DYFS District Office(DO) or Adoption Resource Center (ARC) as delineated at N.J.A.C. 10:15A-1.5(a).**

10:15B-2.1 Description of CCDBG Program

(a) The Child Care and Development Block Grant Program provides low[-] **and moderate** income families with the child care assistance necessary to find and afford quality child care for their children or **for** children who [have been identified by] **are under** DYFS [as] **child** protective services [children and placed in the family's care] **(CSP) supervision including children in DYFS foster care placement.**

(b) (No change.)

(c) CCDBG assistance is intended for "low [-] **and moderate** income" families with a parent(s) who is working or attending a training or education program, or **families** who [has] **have a child under the supervision of DYFS in child** protective services [child, as identified by DYFS residing in the home]; **including foster care.**

1. "Low income" for purposes of the CCDBG Program for [recipient] families **receiving services** is defined as an annual gross family income for the family size that does not exceed 75 percent of the State's median income (SMI) for a family of the same size if the family has been receiving child care services through Departmental child care programs. "Low income" for purposes of the CCDBG program for new applicant families is defined as an annual gross family income for the family size that does not exceed 60 percent of the SMI for a family of the same size. (The SMI for states is published by the Federal Administration for Children and Families in the Federal Register. The SMI was last published in the Federal Register, Vol. 53, No. 64, April 4, 1988. Subsequent updates to the SMI will be published as a public notice by the Department in the New Jersey Register.)

(d) Priority consideration and placement of children through CCDBG assistance is given to children who are from families with "very low income," as well as children who have been identified as **child** protective service children **under the supervision of DYFS, including foster care,** [or] as having special needs **or as having special circumstances** (see N.J.A.C. 10:15-1.2 for definitions of a special needs **or special circumstances** child).

1. Families with "very low income" are defined as families with incomes at or below [200] **185** percent of the Federal Poverty Income Guidelines, as determined by family size.

(e) Groups identified for priority CCDBG participation include:

1. Children [in need of] **who are under child** protective services **supervision, including foster care,** as identified by the Department's Division of Youth and Family Services (DYFS) and defined at N.J.A.C. 10:15-1.2.

2. Children identified as having special needs (see N.J.A.C. 10:15-1.2) and/or in special circumstances, that is, a child that is not under DYFS supervision who has been identified through a written referral from a county welfare agency; DYFS, legal, medical, or social service agency; emergency shelter; **School Based Youth Services Program** or public school which indicates that the child is from a family experiencing medical or social problems or adverse living conditions. Such children require short-term special child care arrangements to help to stabilize or to ameliorate the situation and/or prevent the placement of the child or other family member(s) outside the home. **Children of teen parents are also considered special circumstances children.**

3. Children in families with very low income at or below [200] **185** percent of the Federal Poverty Income Guidelines.

[4. Children from families receiving assistance under the Title IV-A "At-Risk" Child Care Program who are at-risk of becoming ineligible for that child care service assistance, due to an increase in earnings, and who continue to need child care services in order to remain in full-time employment.]

10:15B-2.2 Eligibility for CCDBG Program

(a) Families shall be in need of CCDBG child care assistance in order to remain employed or accept full-time employment or to attend full-time educational and/or work/training programs; or the family has a [protective services] child in need of child care services [residing with the family] **who is under the supervision of DYFS in child protective services, including foster care.**

(b) The child(ren) shall be residing with a family whose annual gross income does not exceed 75 percent of the State's median income for a family of the same size (see N.J.A.C. 10:15B-2.1(c)) for [recipient] families who have been receiving child care services through other Departmental child care service programs; or be residing with an applicant family whose annual gross income does not exceed 60 percent of the SMI for a family of the same size.

(c) The child(ren) under protective service supervision, **including foster care,** where child care has been identified as part of the case plan to ensure that such children receive necessary child care services.

(d)-(f) (No change.)

(g) Families shall make a co-payment toward the cost of care in accordance with N.J.A.C. 10:15C. The exception to the copayment requirement **only** exists **in the CCDBG program** when the child is identified as [a] **one who is in child** protective services [child by] **under the supervision of** DYFS (see N.J.A.C. 10:15-1.2), [who is living in a substitute care setting under the custody of DYFS. No co-payment is determined for such children (see also N.J.A.C. 10:15C-1.1).] **including foster care. Co-Payment fees for these children may be waived on a case by case basis by the DYFS DO or the DYFS Adoption Resource Center (ARC) as delineated in N.J.A.C. 10:15A-1.5(a).**

(h) The child(ren) shall reside with a family where one parent is working or attending a training/education program and the other parent is incapacitated, as defined in N.J.A.C. 10:15-1.2.

10:15C-1.1 Co-payment procedures

(a) All eligible families shall pay a fee toward the cost of child care services. This fee is termed a co-payment.

1. The exception to the co-payment requirement exists **in the CCDBG program** when the child is identified as [a] **under DYFS child** protective services [child by DYFS] **supervision** (see N.J.A.C. 10:15-1.2), **including foster care.** [who is living in a substitute care setting under the custody of DYFS. No co-payment is determined for such children. Additionally, no co-payment is required for purposes of the other Departmental child care programs (for example, the Social Services Block Grant (SSBG) child care program) if the family has children in care through IV-A At Risk or CCDBG and the family is making a co-payment for two children under that program's Requirements; the county designated agency shall verify and document the facts concerning co-payment circumstances under the IV-A At Risk or CCDBG program. The county designated agency shall make contact with the appropriate agency(s) in the county assessing co-payment for the other respective Departmental child care program and inform that agency that the requirement for the co-payment has been met under either the CCDBG or IV-A At Risk program.] **The co-payment for CPS children including foster care may be waived on a case by case basis in the CCDBG program; such a waiver is granted by the DYFS District Office (DO) or the DYFS Adoption Resource Center (ARC) as delineated in N.J.A.C. 10:15A-1.5(a).**

2. Additionally, no co-payment is required for purposes of the other Departmental child care programs (for example, the Social Services Block Grant (SSBG) child care program) if the family has children in care through IV-A At-Risk or CCDBG and the family is making a co-payment for two children under that program's requirements. The county designated agency shall verify and document the facts concerning co-payment circumstances under the IV-A At-Risk and CCDBG program. The county designated agency shall make contact with the appropriate agency(s) in the county assessing co-payment for the other respective Departmental child care programs and inform that agency that the requirement for the co-payment has been met under either the CCDBG or IV-A At-Risk program.

(b) By the adoption of a Statewide co-payment scale for child care service programs provided to families, the programs seek to:

1. [Enable] **In accordance with the eligibility criteria of CCDBG or IV-A At Risk, enable** an eligible family to accept and maintain employment **and**/or to participate in work/training or educational activities through child care service program aid or to provide child care services to a **child in** protective services [child], **including foster care,** as identified by DYFS;

2. (No change.)

3. Require that all [recipient] families [of] **receiving** child care service program benefits [(with the exception of protective service children living in substitute care settings under the custody of DYFS)] **be assessed and/or** pay a portion of the cost of care based on ability to pay, as required by the Omnibus Budget Reconciliation Act of 1990 (Public Law 100-508). **However, the co-payment for CPS children, including foster care, may be waived on a case by case basis in the CCDBG program; such a waiver is granted by the DYFS District Office (DO) or DYFS Adoption Resource Center (ARC) as delineated at N.J.A.C. 10:15A-1.5(a).**

(c) **The co-payment assessed for the family is compiled into one monthly fee for the entire family.** Once assessed, the **total monthly** co-payment is deducted from the amount to be paid **by the county child care agency** to [the] **only one** provider [by the Program] **rendering services to the family (see N.J.A.C. 10:15C-1.3).** This assessed co-payment for child care services is then paid directly by the parent/**applicant** to the provider of care; any remaining balance of the cost of care, up to the maximum rates established by the Department (see N.J.A.C. 10:15A-1.2(c)), is paid by the [Program] **county child care agency.** The child care co-payment policy and procedures are applicable for all types of care arrangements available through the child care service programs including:

1.-5. (No change.)

(d) The amount of the required co-payment is based on the family's annual gross income level, family size, [number of children] **hours of care needed,** and number of children in care. Assessed co-payments are apportioned [weekly] **monthly** and are due for the entire period of time that subsidized child care assistance is received. Holidays, emergency closings, [and]absences, **and starting or ending dates of child care falling within any part of the month** do not exclude or reduce the required **monthly** co-payment. There are two co-payment scales:

Tables I and II (No change.)

(e) The criteria for determination and re-determination of the co-payment are as follows:

1. Family size, which consists of the **parent**/applicant, the **parent's**/applicant's spouse and all children for whom the **parent**/applicant is a legal guardian. **Family size may also include dependent children who are over the age of 18 or other adults who are not legally responsible for the children but who are dependent upon the parent/applicant if the parent/applicant so chooses to include these family members in the application for child care services.**

2. Family income, which includes all gross earned and unearned income received by all members of the family unit defined in (e)1[i] above. The gross annual family income amount must be verified by wage stubs or similar documentation as a condition of receiving child care benefits; and

3. (No change.)

(f) Once the co-payment is determined, it will remain unchanged for the duration of the eligibility period (up to 12 months) unless there is [an increase] **a change** in family size, [a reduction in] gross family income or a change in care from full-time to part-time or vice versa. The participant must notify the county designated agency of any changes occurring in the family related to family size, income, work status or training/**educational program** attendance. The county designated agency shall then determine any changes in the co-payment based on reported circumstances affecting co-payment calculation.

1. An exception shall be made in the case of co-payment for school-age children. The county designated agency will determine a part-time co-payment in accordance with (e) above, for all school-age children, unless the school-age child is in full-time child care for the entire period of the 12 months Parent/Applicant/Provider Agreement. Only in this instance, the co-payment determination will be based on the full-time arrangement.

(g) The co-payment assessment is based on up to two children in care in a family. If more than two children in a family are in care, no co-payment is required for the third and subsequent children in the family. The co-payment is determined on a per [week] **month** basis. [If a family has child(ren) in another of the Departmental child care programs, the county designated agency shall contact the appropriate agency concerning the child care program to determine the final co-payment amount for both programs.]

10:15C-1.2 Process for co-payment assessment

(a) The [weekly] **monthly** co-payment is based on whether the care is full-time or part-time care, on the number of children (up to two per family) in the family needing such care through the program, and on the family's annual gross income level.

(b) If only one child is in care, the [weekly] **monthly** co-payment is the payment which results from Table I or Table II at N.J.A.C. 10:15C-1.1(d). That co-payment is assessed on that family's size, the family's annual gross income, and whether the care is full-time or part-time care for that child, resulting in the co-payment from Table I or Table II.

(c) If two or more children in the family receive child care services through the Program, the [weekly] **monthly** co-payment amount is a [composite] total payment for up to two children in the family receiving such services. The [weekly] **monthly** co-payment sum equals the full co-payment assessed for the first child from Table

I or Table II, plus one-half of the full assessed co-payment for the second child in care from Table I or Table II. The two children are selected for determination of the co-payment from all children in the family in care, based first, on the number of children in the family in full-time care arrangements.

1. If two or more children in the family are in full-time care arrangements, the full co-payment amount is assessed on two children in full-time care. A full co-payment amount is assessed for the first child in full-time care from Table I; to that co-payment amount is added one-half of the full-time co-payment amount for the second child in full-time care from Table I. The resulting [composite] **total monthly** co-payment equals one and one-half of the full-time co-payment amount from Table I based on the family's size and annual income level.

2. If at least one child in the family is in a full-time care arrangement and the second and subsequent children are in part-time care arrangements, the full [weekly] **monthly** co-payment amount is assessed from Table I on the first child in full-time care; to that co-payment amount is added one-half of the part-time co-payment amount from Table II for the second child in part-time care. The resulting [composite] **total monthly** co-payment equals the full-time co-payment assessed amount from Table I plus one-half of the part-time co-payment amount from Table II.

3. If all children in the family are in part-time care arrangements, the full [weekly] **monthly** co-payment amount is based on up to two children in care and is one and one-half times the part-time co-payment amount from Table II for the family's size and income amount.

10:15C-1.3 Provider's receipt of co-payment

(a) The [composite] **total monthly** co-payment is paid to only one provider of care based on the care arrangements of the family. That is, the [composite] **total monthly** co-payment is paid in total to the provider of the highest cost of care arrangement (that is, either the full-time care provider or the provider with the highest reimbursement rate per category of care). The following situations may result and the co-payment shall be distributed as follows:

1. (No change.)

2. If one child is receiving child care services through the Program but more than one provider is involved in giving care, the co-payment from Table I or Table II is paid by the [recipient] **parent/applicant** to that child care provider who provides the highest cost care arrangement (see (a) above).

3. When two children are receiving child care services from the same provider, the [composite] **total monthly** co-payment amount is determined in accordance with N.J.A.C. 10:15C-1.2(c) above, and the sum total is paid by the [recipient] **parent/applicant** to that provider of care. The [composite] total **monthly co-payment** is based on the respective [type] **hours** of care (full-time or part-time) provided each child; the full assessed co-payment fee from Table I or Table II for the first child is added to one-half of the full assessed fee from Table I or Table II for the second child in care with the provider, for the total co-payment amount.

4. When both children are receiving different child care services from separate providers, the child care provider who provides either full-time care or receives the highest reimbursement rate per category of care, will receive from the [recipient] **parent/applicant** the full amount of the [composite] **total monthly** co-payment assessed for both children from Table I or Table II based on the respective type of care provided (full-time or part-time care) for both children.

5. When both children are receiving the same child care services but from different providers (for example both receiving full-time care) the provider assessed at the highest cost of care arrangement receives the full [composite] **monthly** assessed co-payment from the [recipient] **parent/applicant**.

6. When a family has a child(ren) receiving child care services from the voucher program and another Departmental child care program(s), the county designated agency shall contact the appropriate agency to inform them that the family is receiving assistance from the voucher program. In these situations, the provider receiving a subsidy on behalf of the eligible children in the voucher program shall receive the total family monthly co-payment.

(b) (No change.)

[(c) Co-payments shall be rounded down to the nearest dollar.]

(c) The county designated agency will determine a part-time co-payment for all school-age children, in accordance with N.J.A.C. 10:15C-1.1(e), unless the school-age child is in full-time child care for the entire period of the 12 month Parent/Applicant/Provider Agreement. In this instance, the co-payment determination will be based on the full-time arrangement.

10:15C-1.4 Collection, reporting and monitoring of the co-payment; notice of termination

(a) The child care [voucher process will be used by the provider to report child care co-payment collection and] **provider will be responsible for the collection and reporting of all** nonpayment **of the co-payment fee(s)** to the county designated agency. [Co-payments are not required for protective service children identified by DYFS who are living in a substitute care setting.]

(b) The county designated agency is responsible for advising the provider and the [parent/guardian] **parent/applicant** of the co-payment requirement, for training the provider and the [parent/guardian] **parent/applicant** in voucher completion, and for advising both the provider and the [parent/guardian] **parent/applicant** of the consequences of failure to make the required co-payments.

(c) Co-payment collection, monitoring, and procedures for late payment or nonpayment of co-payments and termination of child care benefits are as follows:

1. It is the responsibility of the child care [service] provider to collect co-payments and report nonpayment of co-payments to the county designated agency in accordance with Departmental procedures. Whenever the child care co-payment has not been paid to the provider [by the end of the voucher service period,] **as required,** the co-payment is considered unpaid.

i. In the event of nonpayment of the co-payment by the participant, the provider will [complete the voucher, indicate on the voucher] **provide notice to the county designated agency indicating** the child(ren) for whom the participant failed to pay the required co-payment and [return the voucher to the county designated agency] **the total amount owed by the participant.** This action by the provider will initiate the process for terminating child care benefits.

ii. (No change.)

2. It is the responsibility of the county designated agency to monitor co-payment collection by [examining the completed vouchers returned by providers and] responding to **all notices of** nonpayment of co-payments **which are** reported [on the voucher] **by the provider.**

3. Following receipt of a [voucher] **notice** from a provider indicating nonpayment of the assessed co-payment by the participant, the county designated agency worker shall:

i.-ii. (No change.)

4. The purpose of the letter in (c)3ii above is to provide written notice to:

i. Advise the [parent/guardian] **parent/applicant** of the amount of assessed co-payment monies which have not been paid;

ii. Advise the [parent/guardian] **parent/applicant** of the right to request and obtain a [hearing] **case or administrative review;**

iii. (No change.)

iv. Serve as written confirmation for the provider and the county designated agency that child care services will be terminated due to the late or nonpayment status of the [parent or guardian] **parent/applicant;** and

v. Advise the [parent/guardian] **parent/applicant** to pay the required co-payment arrearages and to contact the county designated agency immediately if overdue co-payment(s) have been paid so that benefits may be continued.

5. Three copies of the notification of termination letter must be completed and signed by the agency worker. The agency worker will:

i. Send the original to the [parent or guardian] **parent/applicant;**

ii. (No change.)

iii. Retain an agency copy [in the parent or guardian's file].

6. [Protective] **In the CCDBG program child protective** services children **including foster care children** identified by DYFS shall not

be terminated until the conditions at N.J.A.C. 10:15A-1.5(d) are met.

7. When child care services are terminated due to nonpayment of the co-payment, the [parent or guardian] **parent/applicant** of a child receiving child care services [retains the right to] **may** request a [hearing of the agency] **case or administrative review**. If child care services are terminated, no payment shall be rendered by the agency under the program from the date of termination until a [hearing] **review** is held [by the agency] and a final determination is made (see N.J.A.C. 10:15A-1.1(f)).

i. In all cases where a [hearing] **case review** is requested of the county designated agency, the agency must adhere to [its] **the** established procedures **of the program**. If the issue is not resolved through the due process proceedings at the county designated agency level, [a fair hearing] **an administrative review** may be requested at [the Divisional level in accordance with DFD hearing procedures at N.J.A.C. 10:81-6] **DFD** for those participants receiving care through the certificate (voucher) process or **a fair hearing** through DYFS for **those receiving care through** contracted child care services (see N.J.A.C. 10:120-3).

(a)

DIVISION OF DEVELOPMENTAL DISABILITIES

Notice of Extension of Comment Period

Determination of Need for a Guardian

Proposed Readoption with Amendments: N.J.A.C. 10:43

Take notice that the comment period for the proposed readoption with amendments of N.J.A.C. 10:43, published in the July 18, 1994 New Jersey Register at 26 N.J.R. 2838(a), has been extended from August 17, 1994 to September 14, 1994.

Submit comments by September 14, 1994 to:

James Evanochko or Deborah Barry
Division of Developmental Disabilities
CN 726
Trenton, N.J. 08625

(b)

DIVISION OF DEVELOPMENTAL DISABILITIES

Family Support Service System

Proposed New Rules: N.J.A.C. 10:46A

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:6D-33 et seq., specifically 30:6D-41.

Proposal Number: PRN 1994-457.

Submit comments by September 14, 1994 to:

James M. Evanochko
Administrative Practice Officer
Division of Developmental Disabilities
CN 726
Trenton, New Jersey 08625

The agency proposal follows:

Summary

On March 29, 1993, the Family Support Act, P.L. 1993, c.98, was signed into law. The law requires that the Division of Developmental Disabilities, within the Department of Human Services, create a system of family support that is flexible, coordinated, family-driven and designed to strengthen and promote families that provide care at home for a loved one with a developmental disability.

Because the family is so important, one of the best possible uses of society's resources is to support families. Family support makes it possible for many families to get support services in their home that in the past were not available.

Family support is not a single service, but a varied network of supports that can change with individual family needs. Since no two families or persons with disabilities are exactly alike, the supports needed by one family might differ greatly from that needed by another family.

The family support system shall include, but not be limited to, after-school care; cash subsidies; communication and interpreter services; counseling services; crisis intervention; day care; equipment and supplies; estate and transition planning; home and vehicle modification; home health services; homemaker assistance; housing assistance; medical and dental care; parent education and training; personal assistance services; recreation services; respite care for families; self-advocacy training; service coordination; specialized diagnosis and evaluation; specialized nutrition and clothing; therapeutic or nursing services; transportation; voucher services; and other services identified by the family.

The proposed new rules will change the way families receive support services from the Division. The Statewide family support policy must acknowledge that families themselves are able to define their own needs and select their own services within available resources. Families, through the Regional Family Support Planning Councils, will decide what family support services are needed in their area or region and make recommendations to the Division of Developmental Disabilities.

N.J.A.C. 10:46A-1.1 describes the purpose and authority of the rules. It states that the Division of Developmental Disabilities in conjunction with the New Jersey Developmental Disabilities Council, must create a system of family support that is flexible and designed to strengthen and promote families that provide care at home for a family member with a developmental disability.

It notes that a Statewide family support policy must acknowledge that families themselves are able to define their own needs and select their own services; within available resources, family supports must be chosen by the families, controlled by families and monitored by families.

It also states that the amounts of funds for family support services shall be subject to the funding available in the current fiscal year.

N.J.A.C. 10:46A-1.2 indicates that the rules apply to eligible persons with developmental disabilities and/or their families. The provisions of the rules also apply to agencies under contract with or regulated by the Division, within the Department of Human Services.

N.J.A.C. 10:46A-1.3 contains the definitions used in the rules.

N.J.A.C. 10:46A-2.1 outlines the criteria for eligibility.

N.J.A.C. 10:46A-2.2 states who may apply for family support services.

N.J.A.C. 10:46A-2.3 states where and how to request family support services. It states how families are notified of the decision regarding the request for family support services. It also states how to appeal a family support service decision.

N.J.A.C. 10:46A-3.1 details the role and responsibilities of the Family Support Coordinator.

N.J.A.C. 10:46A-4.1 describes the composition requirements of the membership of the Regional Family Support Planning Councils.

N.J.A.C. 10:46A-4.2 outlines the responsibilities of the Regional Family Support Planning Councils.

N.J.A.C. 10:46A-4.3 describes the composition requirements of the membership and responsibilities of the Statewide Family Support Council.

Social Impact

The Division currently serves approximately 18,000 individuals with developmental disabilities. Due to the lack of supports and services needed in the home, many families have no alternative but to place their family member with a developmental disability out of the home.

The proposed new rules are expected to have a positive social impact in that they will afford families a greater control over the type of family support services they receive and allow their family member with a developmental disability to stay at home longer than might otherwise be possible.

Economic Impact

The proposed new rules will have a positive economic impact on individuals with a developmental disability and the families who take care of the individual in their own homes.

The proposed new rules are not a new program but a systems change. Under this systems change, individuals with developmental disabilities and their families now will choose, control and monitor their own family supports.

No funds have been allocated for this act. In Fiscal Year 1994, the Division spent approximately $12 million to provide supports to both individuals and families. The Division anticipates the same dollar amount for Fiscal Year 1995. Since the act only refers to family supports, the Division will segregate those funds that are allocated to individual supports from the total.

Families that reside in New Jersey and meet eligibility requirements of the DDD as set forth in N.J.A.C. 10:46 and the income, need and other criteria established by the Commissioner, Department of Human Services, will be eligible for Family Support services.

Regulatory Flexibility Statement

In addition to affecting the way in which the Division of Developmental Disabilities will deliver family support services, approximately 800 private service providers, under contract with, or regulated by, the DDD will be affected by the proposed new rule, some of whom may be classified as small businesses pursuant to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The proposed new rules permit families and individuals with a developmental disability to choose, control and monitor their own support services, and the provider agencies will now be required to deliver the services determined by the families to be necessary, not what the providers determine necessary. To the extent this focus changes what providers do, the providers will be affected.

Because of an overriding concern for the welfare, safety and health of individuals with a developmental disability and their families, the Department will not exempt any small businesses from compliance with the proposed new rule.

Full text of the proposed new rules follows:

CHAPTER 46A
FAMILY SUPPORT SERVICE SYSTEM

SUBCHAPTER 1. GENERAL PROVISIONS

10:46A-1.1 Purpose; authority

(a) Pursuant to N.J.S.A. 30:6D-33 et seq., the Division of Developmental Disabilities, in conjunction with the New Jersey Developmental Disabilities Council must create a system of family support that is flexible and designed to strengthen and promote families that provide care at home for a family member with a developmental disability.

(b) A Statewide family support policy must acknowledge that families themselves are able to define their own needs and select their own services; within available resources, family supports must be chosen by the families, controlled by families and monitored by families.

(c) The system of Family Support shall include, but not be limited to:

1. After school care;
2. Cash subsidies;
3. Communication and interpreter services;
4. Counseling services;
5. Crisis intervention;
6. Day care;
7. Equipment and supplies;
8. Estate and transition planning;
9. Home and vehicle modification;
10. Home health services;
11. Homemaker assistance;
12. Housing assistance;
13. Medical and dental care not otherwise covered;
14. Parent education and training;
15. Personal assistance services;
16. Recreation services;
17. Respite care for families;
18. Self advocacy training;
19. Service coordination;
20. Specialized diagnosis and evaluation;
21. Specialized nutrition and clothing;
22. Therapeutic or nursing services;
23. Transportation;
24. Vouchers; and
25. Other services as identified by the family, in accordance with N.J.A.C. 10:46A-2.3.

(d) The Commissioner shall establish income, need and other criteria, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., to ensure that the expenditures for the Family Support System are within the limits of available funding.

(e) The amounts of funds for family support services shall be subject to the funding available in the current fiscal year.

(f) Adults with developmental disabilities should be afforded the opportunity to make decisions for themselves, live in typical homes within their own communities and exercise their full rights as citizens. Adults with developmental disabilities should have options for living separately from their families, but, when this is not the case, families should be provided the supports they need, within available funding limits.

10:46A-1.2 Scope

The provisions of this chapter shall apply to all eligible persons with developmental disabilities and/or their families. The provisions of this chapter also apply to agencies under contract with or regulated by the Division of Developmental Disabilities, within the Department of Human Services.

10:46A-1.3 Definitions

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

"Adult" means any individual 18 years of age and older.

"Developmental disability" means a severe, chronic disability of a person which:

1. Is attributable to a mental or physical impairment or combination of mental or physical impairments;
2. Is manifest before age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and
5. Reflects the need for a combination and sequence of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.
6. Developmental disability includes, but is not limited to, severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met. (N.J.S.A. 30:6D-25.)

"DDD Family Support Coordinator" means the individual designated by the Regional Administrator to coordinate the region's family support program.

"Developmental Disabilities Council" (DDC) means the Federally-mandated State planning and advisory board composed of 28 members appointed by the Governor.

"Division" means the Division of Developmental Disabilities within the Department of Human Services.

"Family" means the family member with a developmental disability and his or her parents, siblings, spouse, and/or children, or uncompensated caregiver.

"Functional services" means those services and programs available to provide a person with a developmental disability: education, training, rehablitation, adjustment, treatment, care and protection. (N.J.S.A. 30:4-23)

"Family support" means a coordinated system of on-going public and private supports, services, resources, and other assistance, which are designed to maintain and enhance the quality of life of a family member with a developmental disability and his or her family.

"Family Support Coordinator" means a coordinator working under the direction of the Developmental Disabilities Council (DDC) who shall be a person qualified by training and experience to perform the duties of his or her office.

"Level of service" means the contracted number of units of service to be delivered and the actual number of units of service delivered.

"Parent" means the biological or adoptive parent or uncompensated foster parent or legal guardian.

"Resident" means a person who is a domiciliary of New Jersey for other than a temporary purpose and who has no present intention of moving from the State.

"Support services" means services provided to a person with a developmental disability and his or her family that are generally of

short term duration, or are a specific type of care, treatment, training, assistance or device that will help the individual avoid the need for more intensive care which would require coordination of a sequence of generic or specialized services.

"Uncompensated caregiver" means the person, including, but not limited to, a parent, sibling, spouse, child, grandparent, step family member, aunt, uncle, cousin or legal guardian, who, without monetary payment, cares for the family member with a developmental disability and with whom the family member with a developmental disability resides.

SUBCHAPTER 2. ELIGIBILITY CRITERIA

10:46A-2.1 General eligibility

(a) A person determined to have a developmental disability in accordance with the requirements of N.J.A.C. 10:46 and who is a resident of the State of New Jersey, shall be eligible for family support services.

1. In accordance with N.J.A.C. 10:46, a person with a developmental disability can be determined to be eligible for either functional services, or for support services only.

(b) A person with a developmental disability must either live with a family member or an uncompensated caregiver. The requested family support services are provided to support the family.

(c) The DHS and any publicly funded agency which provides family support services shall assist families in obtaining all other sources of funding before using funds available for the purpose of this chapter.

10:46A-2.2 Who may apply for family support services

(a) Requests for family support services may be made by:

1. A competent adult on his or her own behalf;
2. An uncompensated caregiver;
3. A parent, family member or a legal guardian of an incompetent adult; or
4. The parents or legal guardian of a minor.

10:46A-2.3 Requests for family support services

(a) Requests for family support services shall be made to a regional office of the Division.

1. An individual not previously determined eligible for Division services and who is requesting family support services shall contact the regional intake worker to initiate the eligibility process.

2. If an individual is eligible for functional services of the Division, requests for family support services shall be made to the assigned case manager.

3. If an individual is eligible for support services only, in accordance with N.J.A.C. 10:46-2.3, the request for family support services shall be made to a DDD regional family support coordinator.

(b) The request shall be made by telephone, in writing or by appearing in person to the appropriate regional office of the Division as noted below.

Regional Office	Counties of Jurisdiction
Northern Regional Office 201-927-2600 1 B Laurel Drive Flanders, NJ 07836	Sussex, Morris, Warren, Passaic, Bergen, Hudson
Upper Central Reg. Office 201-379-1700 65 Springfield Avenue Springfield, NJ 07081	Essex, Somerset, Union
Lower Central Reg. Office 609-292-4500 Capital Place 1 222 So. Warren Street Trenton, NJ 08625	Middlesex, Monmouth, Mercer, Ocean, Hunterdon
Southern Regional Office 609-757-4700 101 Haddon Avenue Suite 17 Camden, NJ 08103	Camden, Atlantic, Gloucester, Cumberland, Salem, Cape May, Burlington

(c) Minimum information submitted shall include, but not be limited to:

1. The name of the person for whom family support services is requested and the presenting disability;
2. The specific family support services requested;
3. The length of time specific family support services will be needed, if known;
4. The name, address and telephone number of a family contact person; and
5. Such other information as needed by the Division to consider a person's request.

(d) The family shall be notified within 10 working days by telephone, or in writing, by a DDD regional family support coordinator or case manager of the approval, denial, modification or status of the requested family support services.

(e) A DDD regional family support coordinator, in conjunction with the family and regional staff, will evaluate the needs of individuals and their families who are receiving family support services and the availability of family support resources on an ongoing basis.

(f) Individuals who disagree with a Family Support Service decision may appeal the decision in accordance with the provisions of N.J.A.C. 10:48-1, Appeal Procedure.

SUBCHAPTER 3. FAMILY SUPPORT COORDINATOR

10:46A-3.1 Role of the Coordinator

(a) The family support system shall be administered by the Division, in conjunction with the Family Support Coordinator working under the direction of the Developmental Disabilities Council.

(b) The Division of Developmental Disabilities shall develop an agreement with the Developmental Disabilities Council regarding the role and authority of the Coordinator.

(c) The Family Support Coordinator shall:

1. Coordinate efforts by Regional Planning Councils and public and private agencies, including, but not limited to:

i. Identification of services provided by different agencies to avoid duplication; and

ii. Planning with all agencies to insure that gaps in services are filled;

2. Adopt, review and revise, no less than annually, a State Family Support Plan, that is based on the annual reports of the Regional Planning Councils, which shall:

i. Assess needs, establish goals, and set priorities for the provision of family supports for individuals with developmental disabilities;

ii. provide for outreach and coordinated delivery of family supports;

3. Provide administrative support services to each of Regional Planning Councils and the Statewide Council;

4. Participate as a non-voting member of the Statewide Family Support Council;

5. Develop and implement a training plan for family support as identified by the Regional Planning Council in the annual reports; and

6. Respond to public inquiries and requests for information regarding family support.

SUBCHAPTER 4. REGIONAL FAMILY SUPPORT PLANNING COUNCILS

10:46A-4.1 Membership

(a) DDD and DDC will ensure that two Regional Family Support Planning Councils shall be established in each of the four DDD regions within 90 days after adoption of this chapter.

(b) The need to establish additional councils or merge existing councils shall be evaluated within one year and annually thereafter by the Statewide Family Support Council in conjunction with the

Regional Family Support Planning Council(s). Councils can be added or merged as the needs indicate. Minimally, there shall be one council per region.

(c) Each Regional Family Support Planning Council shall be comprised of no more than 11 members. All members shall be either a person with a developmental disability or a family member of a person with a developmental disability.

(d) Initially, six members of the Regional Family Support Planning Council shall serve three year terms, five members shall serve two year terms. Thereafter, all members shall serve a two year term. No member shall serve for more than seven consecutive years.

(e) All Regional Family Support Planning Council members shall receive initial orientation and ongoing training and support.

(f) Initially, members of the Family Support Advisory Group may serve on a Regional Family Support Planning Council. The Advisory Group will nominate the additional members to reflect the cultural, economic, ethnic, geographic and disability diversity of the region it serves by soliciting information from interested individuals.

(g) As terms expire, individuals will be nominated by the Regional Family Support Planning Council membership, reflecting the cultural, economic, ethnic, geographic and disability diversity of the region it serves.

(h) Names of individuals interested in Regional Family Support Planning Council membership shall be maintained by the Regional Family Support Planning Council and/or Family Support Coordinator. Nominees shall be taken from this list.

(i) All Regional Family Support Planning Council members shall be appointed by the Commissioner, Department of Human Services.

(j) A chairperson and vice-chairperson shall be elected for each Regional Family Support Planning Council. These individuals, or two other designated representatives as chosen by the Regional Family Support Planning Council, shall serve on a Statewide Family Support Council.

(k) Council members shall serve without compensation beyond reimbursement for reasonable transportation, child care and other costs related to serving on the council.

(l) Regional Family Support Planning Councils shall meet at least quarterly. Individual councils may establish more frequent meeting schedules based on the needs of the council.

(m) No member of the Regional Family Support Planning Council who is an employee or board member of an agency under contract with the DDD providing family support services shall enter into discussion or cast a vote on any matter which would provide a direct financial benefit to that agency.

10:46A-4.2 Responsibilities of the Regional Family Support Planning Councils

(a) Each Regional Family Support Planning Council shall work to establish and expand family support in its region.

(b) Each Regional Family Support Planning Council shall develop and implement a method of obtaining public input that provides the opportunity to express comments and share concerns and information about family support.

1. Public input shall include public meetings, that are held locally at a time and place that is convenient for the families.

2. Attendance records and written minutes shall be made available to the Family Support Coordinator and the DDD.

3. Based on the needs of the region the Regional Family Support Planning Council serves, at least two additional means of obtaining public input shall also be utilized to ensure all interested individuals are represented.

(c) Each Regional Family Support Planning Council shall monitor the implementation of the family support system to ensure that the system is meeting the mandates of the legislation and the extent to which family-centered outcomes are achieved. Monitoring shall, at a minimum, address the following:

1. The effectiveness of the public awareness and outreach activities supported by the Division of Developmental Disabilities and the Developmental Disabilities Council;

2. The diversity of the families accessing the system in comparison to the demographics of the area;

3. Family satisfaction with regard to the system;

4. The practices of DDD and provider agencies, as it relates to Family Support, including the implementation of the eligibility criteria;

5. A review of family support resources to determine the extent to which they meet the needs of the families in the regions; and

6. Levels of service.

(d) Each Regional Family Support Planning Council shall, based on the results of the public input and monitoring activities, advise and assist DDD annually on the allocation of family support resources for the region the council serves.

1. By December 15th of each year, DDD shall provide each Regional Family Support Planning Council with estimated figures representing the allocation of existing resources for family support at State and regional levels.

2. Each Regional Family Support Planning Council shall submit a plan to DDD, by February 15th of each year, which includes advice on how these resources can best meet the needs of the families that reside within the region that the council serves.

3. The recommendations shall include advice on the equitable distribution of resources within the region.

4. Each Regional Family Support Planning Council shall develop a plan which ensures that no later than the end of the third year after adoption of these rules, all family support resources are expended in accordance with the principles established in the Family Support Act.

5. DDD will inform each Regional Family Support Planning Council of any new funds for family support services no later than 15 days following the notification of receipt of funds. Within 30 additional days, each Regional Family Support Planning Council will make recommendations to DDD regarding the new funds. The Regional Family Support Planning Councils will also make recommendations about the allocation of such funds.

(e) Each Regional Family Support Planning Council shall develop an annual report, for submission to the Family Support Coordinator, which shall include:

1. A description of information-gathering process;

2. Monitoring results and data collected;

3. An evaluation of the family support system;

4. Long and short-term recommendations, based on successes and areas for improvements; and

5. Identification of training needs for family support.

(f) Each Regional Family Support Planning Council's annual report shall be made available, upon request, through the Family Support Coordinator.

10:46A-4.3 Statewide Family Support Council

(a) The membership and responsibilities of the Statewide Family Support Council shall be as follows:

1. The Council shall be comprised of a chairperson and a vice-chairperson, or two other designated representatives, from each Regional Family Support Planning Council.

2. The Council shall elect a chairperson, vice-chairperson and a secretary, each of whom will serve for a minimum one year term.

3. The Council shall meet a minimum of once every six months.

4. The Council shall come together for sharing of information, concerns and problem solving. Attendance records and written minutes will be made available to each Regional Family Support Planning Council and the Family Support Coodinator.

5. The Council shall annually approve the Statewide Family Support Plan adopted by the Coordinator for submission to the Commissioner.

(b) The Statewide Family Support Plan shall be made available, upon request, through the Family Support Coordinator.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration
Pharmaceutical Services Manual
Manual for Hospital Services
Manual for Special Hospital Services
Manual for Physicians' Services Manual
Certified Nurse-Midwifery Services
Independent Laboratory Services
Independent Clinic Services Manual
Limitation on Reimbursement for Infertility Services

Proposed Amendments: N.J.A.C. 10:49-5.2, 5.3 and 5.4; 10:51-1.12; 10:52-1.3, 1.7 and 1.8; 10:53-1.6 and 1.7; 10:54-1.2; 10:58-1.3; 10:61-1.3 and 3.2; and 10:66-2.3

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-3i(1) through (8); 30:4D-6a(1)(2)(3)(5) and b(3)(6)(17)(18); 30:4D-12.

Agency Control Number: 94-P-27.

Proposal Number: PRN 1994-453.

Submit comments by September 14, 1994 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN 712, Mail Code #26
Trenton, New Jersey 08625-0712

The agency proposal follows:

Summary

The amendments, upon adoption, will eliminate reimbursement to providers for services primarily for the diagnosis and treatment of infertility. These services include such procedures as sterilization reversals, and related office (clinic or medical) visits, drugs, laboratory services, radiological and diagnostic services, and other surgical procedures. The amendents do not impact the reimbursement to hospitals, special hospitals, independent clinics, physicians, certified nurse midwives, and independent clinical laboratories for services related to family planning, contraceptive and genetic counseling procedures.

Family planning includes medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling. Federal regulations (42 CFR 440.40(c) and 42 CFR 440.250(c)) allow States latitude in defining family planning services to include only those services which either prevent or delay pregnancy, or more broadly, to define the term to include services for the treatment of infertility.

The New Jersey Medicaid program presently provides family planning services including the diagnosis and treatment for infertility-related services. The elimination of services related to infertility will impact upon both the categorically needy and the Medically Needy Medicaid recipient.

A review of the Division's policy and input from the public and other affected agencies, has lead the Division to reconsider its policy in this area. Therefore, the Division is proceeding with these proposed amendments to implement a change in the Medicaid coverage of infertility-related services. The Medical Assistance Advisory Council (MAAC) of the Division of Medical Assistance and Health Services also indicated that they support the recommendation that the Division discontinue paying for infertility services.

The amendments cover each manual which covers rules for providers who provide infertility-related services. The Administration chapter is included in the proposal, as it lists the overall services that are provided by the New Jersey Medicaid program.

It is understood that many of the infertility-related services are also provided for conditions other than primarily to diagnose and treat infertility. When an office (clinic or medical) visit, drug, laboratory service, radiology service, diagnostic service, or surgical procedure is provided for conditions other than primarily for the diagnosis and treatment of infertility, the New Jersey Medicaid program will continue to reimburse claims for these services. Providers must submit for medical review and the approval of payment, claims for services which, although used primarily for the treatment of infertility, may also be used for treatment of unrelated diseases and conditions.

Social Impact

The impact of these amendments is primarily social. The amendments, when adopted, will eliminate Medicaid reimbursement for infertility-related services. In the future, a Medicaid recipient will be required to pay for medical services provided primarily for the treatment of infertility. Medicaid reimbursement for other family planning services, including contraceptive and genetic counseling, will continue.

Economic Impact

Medicaid recipients are not required to pay towards the costs of Medicaid-covered services. If the service is a non-covered Medicaid service, payment for the service is between the patient and the provider. Since services provided primarily for the diagnosis and treatment of infertility will no longer be Medicaid covered services, the Medicaid recipient will be financially liable for the cost of these services.

It is anticipated that there will be a reduction of expenditures to the Medicaid program. For calendar year 1993, the Division expended $352,414, determined through a 1993 claims processing review, for medical, surgical and laboratory services, and $171,152 for infertility drugs. Since Federal share represents a 90 percent match on these services, State expenditures totaled $52,356.

The impact on Medicaid providers should be minimal, since the total expenditures for infertility services were dispersed over several provider types.

Regulatory Flexibility Analysis

An undeterminable number of physicians, independent clinics, certified nurse-midwives, hospitals, special hospitals, pharmacies, and independent laboratories who provide infertility-related services are affected by these proposed amendments as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments impose record keeping or other compliance requirements on these small businesses. Medical providers are presently required to document the procedures and treatments provided. In addition, providers who provide services that are the same as those provided for the treatment of infertility, but are provided for conditions/diseases other than the diagnosis and treatment of infertility will be reconsidered for reimbursement by documentation of medical justification of the treatment.

There is no differentiation in the proposed amendments based on the size of the provider who provides infertility-related services. These providers are required to have or obtain sufficient professional personnel to provide for patient care.

There should be no capital costs associated with these amendments.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:49-5.2 Services available to recipients eligible for the regular Medicaid Program

(a) The services listed below, in alphabetical order, are available to recipients eligible for the regular Medicaid Program:

1.-6. (No change.)

7. Family planning services[:] **including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.**

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical and clinic) visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

8.-28. (No change.)

10:49-5.3 Services available to recipients eligible for the medically needy program

(a) Regular Medicaid services are available to Medically Needy recipients except for the following services which are not available or are not available to certain eligible Medically Needy groups: (See the service code next to the recipient's name on the Medicaid

Eligibility Identification Card to ascertain the Medically Needy group under which the recipient's eligibility was established; that is, Group A—pregnant women, Group B—needy children, and Group C—aged, blind and disabled.)

1.-9. (No change.)

10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures are not available to the Medically Needy group.

10:49-5.4 Services not covered by Medicaid Program

(a) Listed below are some general services and items excluded from payment under the New Jersey Medicaid [Program] **program**. There are specific exclusions and limitations detailed in the second chapter of each Provider Services Manual. Payment is not made for the following:

1.-13. (No change.)

14. Any claim submitted by a provider for service(s) rendered, except in a medical emergency, to a Medicaid recipient whose Medicaid Eligibility Identification Card (FD-73/178) has a printed message restricting the recipient to another provider of the same service(s). (See N.J.A.C. 10:49-2.13(e)2, Special Status Program); [and]

15. Services or items reimbursed based upon submission of a cost study when there are no acceptable records or other evidence to substantiate either the costs allegedly incurred or recipient income available to offset those costs. In the absence of financial records, a provider may substantiate costs or available income by means of other evidence acceptable to the Division. If upon audit, financial records or other acceptable evidence are unavailable for these purposes:

i.-ii. (No change.)

iii. The Division shall seek recovery of any resulting overpayments[.]; **and**

16. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office (medical or clinic), drugs, laboratory services, radiological and diagnostic services and surgical procedures.

10:51-1.12 Non-covered pharmaceutical services

(a) The following classes of prescription drugs or conditions are not covered under the New Jersey Medicaid program. For recipients in the Medically Needy component of the New Jersey Care ... Special Medicaid programs, pharmaceutical services are not available to the aged, blind nor the disabled. For information on how to identify a covered person, see N.J.A.C. 10:49, Administration.

1.-15. (No change.)

16. If the provider has a delivery service, he or she may waive or discount delivery charges to the recipient but is prohibited from charging more than his or her usual customary charge to the general public for delivery; [and]

17. Preventive vaccines, biologicals and therapeutic drugs distributed to hospital clinics and/or community health centers by the New Jersey Department of Health[.]; **and**

18. Drugs provided primarily for the treatment of infertility or which may be used to treat other conditions related to infertility, including fertility preparations and gonadotropic (follicle stimulating and luteinizing) hormones.

i. When a drug is provided that is ordinarily considered an infertility drug, but is provided for conditions unrelated to infertility, the claim must be sent with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

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

10:52-1.3 Noncovered inpatient hospital services

(a) Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

1.-16. (No change.)

17. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital shall submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

(b) (No change.)

10:52-1.7 Covered outpatient hospital services

(a) Approved hospital outpatient departments may provide the following services to outpatients when medically necessary:

1.-15. (No change.)

16. Family planning services **including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;**

17.-18. (No change.)

(b) (No change.)

10:52-1.8 Noncovered outpatient hospital services

(a) Approved hospital outpatient departments will not be reimbursed for any of the following:

1.-8. (No change.)

9. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory services, radiological and diagnostic services, and surgical procedures.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

10:53-1.3 Noncovered inpatient special hospital services

(a) Benefits are not payable for any services rendered or items dispensed or furnished in connection with:

1.-16. (No change.)

17. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory, radiological and diagnostic services and surgical procedures.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

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

10:53-1.6 Covered outpatient hospital services

(a) Approved special hospital outpatient departments may provide the following services to outpatients when medically necessary:

1.-15. (No change.)

16. Family planning services **including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling;**

17.-18. (No change.)

(b) (No change.)

10:53-1.7 Noncovered outpatient special hospital services

(a) Approved **special** hospital outpatient departments will not be reimbursed for any of the following:

1.-9. (No change.)

10. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related medical visits, drugs, laboratory services, radiological and diagnostic services, and surgical procedures.

i. Exception: When service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the hospital must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

10:54-1.2 Scope of serivce

(a) Payment will be made for the medically necessary services, subject to the following limitations:

1.-9. (No change.)

10. Family planning services including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

i. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

(1) Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the physician must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

10:58-1.3 Scope of service

(a)-(d) (No change.)

(e) Family planning services may be provided including medical history and physical examination (including pelvic and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

1. Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures are not covered by the New Jersey Medicaid program.

i. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the certified nurse midwife must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

10:61-1.3 Limitations on laboratory services

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

(d) Laboratory services provided primarily for the diagnosis or treatment of infertility are not covered by the New Jersey Medicaid program.

1. For those HCPCS procedure codes which are determined to be primarily for the diagnosis of infertility, refer to the HCPCS subchapter of this chapter and the Indicator "F".

10:61-3.1 Introduction

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

(c) Regarding specific elements of HCPCS codes which requires attention of provider, the lists of HCPCS code numbers for Pathology and Laboratory are arranged in tabular form with specific information for a code given under columns with titles such as: "IND", "HCPCS CODE", "MOD", "DESCRIPTION", and "MAXIMUM FEE ALLOWANCE". The information given under each column is summarized below:

Column Title	Description
IND	(Indicator-Qualifier) Lists alphabetic symbols used to refer provider to information concerning the New Jersey Medicaid Program's qualifications and requirements when a procedure or services code is used. Explanation of indicators and qualifiers used in this column are given below: "A" preceding any procedure code indicates that these tests can be and are frequently done as groups and combinations (profiles) on automated equipment. **"F" preceding any procedure code indicates that the code primarily for the diagnosis and treatment of infertility, and therefore, is not covered by the New Jersey Medicaid program, in accordance with N.J.A.C. 10:61-1.3(d).** "L" preceding any procedure code indicates that the complete narrative for the code is located in the Appendix A of this Pathology and Laboratory section. "M" preceding any procedure code indicates that this service is a medical necessity procedure. Refer to Appendix D of this Pathology and Laboratory section. "N" preceding any procedure code indicates that qualifiers are applicable to that code. These qualifiers are listed by procedure code number in Appendix B of this Pathology and Laboratory section.
HCPCS CODE	Lists the HCPCS procedure code numbers.
MOD	Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be idenditifed by the addition of alphabetic and/or numeric characters at the end of the code. The New Jersey Medicaid Program's recognized modifier codes are listed at N.J.A.C. 10:61-3.5.
DESCRIPTION	Lists the code narrative. (Narratives for Level I codes are found in CPT-4. Narratives for Level II and Level III codes are found at N.J.A.C. 10:61-3.3).
MAXIMUM FEE ALLOWANCE	Lists New Jersey Medicaid Program's maximum reimbursement schedule for Pathology and Laboratory services. If the symbols "B.R." (By Report) are listed instead of a dollar amount, it means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the MC-13A C2 claim form.

1.-2. (No change.)

(d) (No change.)

10:61-3.2 HCPCS code numbers and maximum fee schedule; pathology/laboratory (CPT-4)

			Maximum Fee Allowance		
Ind	HCPCS Code	MOD	Office Total Fee	$	Prof. Comp.
...					
F	**89329**		**31.00**		
F	**89330**		**8.00**		
...					

10:66-2.3 Family planning

(a) Family planning services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continued medical supervision, [and] continuity of care, [including services related to infertility.] **and genetic counseling. Services provided primarily for the diagnosis and treatment of infertility, including sterilization reversals, and related clinic visits, drugs,**

laboratory services, radiological and diagnostic services, and surgical procedures are not covered by the New Jersey Medicaid program.

1. Exception: When a service is provided that is ordinarily considered an infertility service, but is provided for another purpose, then the independent clinic must submit the claim with supporting documentation for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Medical Affairs and Provider Relations, CN 712, (Mail Code #14), Trenton, New Jersey 08625-0712.

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

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration

Recoveries Involving County Welfare Agencies

Proposed Amendment: N.J.A.C. 10:49-14.4

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-7, 7a, b, c, i, and r.

Agency File Number: 94-P-13.

Proposal Number: PRN 1994-423.

Submit comments by September 14, 1994 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
Mail Code 26
CN 712
Trenton, NJ 08625-0712

The agency proposal follows:

Summary

The proposed amendment deals with recoveries that are an administrative matter between the county welfare agencies (CWAs) and the Division of Medical Assistance and Health Services (DMAHS). DMAHS' current policy is to provide CWAs an incentive payment of 25 percent of any amount recovered with their assistance for DMAHS as a result of improperly granted medical assistance (to a recipient) discovered pursuant to the Unearned Income component of the Income and Eligibility Verification System (IEVS). In essence, the IEVS system has several computer matches, one of which includes unearned income, such as interest. If the CWA obtains a recovery of improperly granted medical assistance, the CWA forwards the recovery to DMAHS and receives an incentive payment of 25 percent for its participation in the collection process.

However, the current policy does not allow for an incentive payment for a recovery of improperly granted medical assistance not generated as a result of the Unearned Income component of the IEVS system. DMAHS' policy, as indicated in N.J.A.C. 10:49-14.4(b)4, is to require the CWAs to make full repayment to DMAHS from the net proceeds of any recovery.

This amendment proposes to change this policy by applying the same 25 percent incentive payment to recoveries of improperly granted medical assistance that do not result from the Unearned Income component of the IEVS. Therefore, whenever the CWAs make a recovery of improperly granted medical assistance for DMAHS, they will receive an incentive payment of 25 percent of the gross recovery. The amendment should provide a much more efficient process, facilitating the recovery and payment process for DMAHS and the CWAs.

Exceptions for Non-IEVS payments received by CWAs on or after July 1, 1989 and IEVS payments received by either DMAHS or CWAs on or after July 1, 1989 have been added at N.J.A.C. 10:49-14.4(b)1 and 2.

Social Impact

This proposed amendment potentially impacts on that segment of the Medicaid population that has been improperly granted medical assistance because they, or those responsible for generating the overpayment, will be required to make repayment. The amendment impacts on CWAs who will effect and forward such collections to DMAHS of inappropriate Medicaid expenditures due to improperly granted medical assistance. The CWAs will be paid 25 percent of the amount recovered, regardless of whether or not the improperly granted assistance was identified pursuant to the Unearned Income component of IEVS.

This amendment does not impact on Medicaid providers.

Economic Impact

This proposed amendment does not change DMAHS' policy with the CWAs regarding collecting incorrect medical assistance, which is currently in place. However, this amendment permits the CWAs to receive 25 percent of the gross reimbursement for recoveries not originating from the Unearned Income component of IEVS, which are made on behalf of DMAHS. Although the amount of additional recoveries which can be collected as a result of this incentive is unknown, it is anticipated that recoveries will increase, since the counties now should have greater incentive to pursue recovery.

Regulatory Flexibility Statement

The proposed amendments do not impact on small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16. Therefore, no regulatory flexibility analysis is required because small businesses are not affected. The "persons" affected are governmental agencies (DMAHS and county welfare agencies), Medicaid recipients, and potentially others responsible for the improperly granted medical assistance. These "persons" would not be considered small businesses.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated by brackets [thus]):

10:49-14.4 Recoveries involving county welfare agencies

(a) (No change.)

(b) The following pertain to incorrectly granted assistance (cash and/or medical assistance):

1.-3. (No change.)

4. When collection occurs in a case involving both cash assistance and medical assistance, the CWA shall, in the absence of court instruction to the contrary, apply the [net] proceeds[, after deducting identifiable costs of collection such as filing fees and advertising costs but not including such costs as CWA staff time, supplies, counsel fees or overhead,] to the repayment of cash assistance and the reimbursement of DMAHS **for medical assistance. The reimbursement to DMAHS shall be payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.**

5. When in any case a CWA recovers only **for** medical assistance improperly granted, the CWA shall [reimburse itself for those case expenses directly related to the recovery such as filing fees and advertising costs but not including costs such as CWA staff time, supplies, counsel fees or overhead. In addition, the CWA shall retain 10 percent of the gross amount of the recovery up to $250.00. The CWA shall] remit the [remaining] proceeds to DMAHS. The reimbursement **to DMAHS** shall be payable to the Treasurer, State of New Jersey[.], **who will then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.**

6. When any CWA action, whether alone or in combination with DMAHS, results in a recovery of improperly granted medical assistance from a case generated by the Internal Revenue Service (IRS) unearned income component of the IEVS match, all funds recovered shall be remitted to DMAHS payable to the Treasurer, State of New Jersey, which shall then reimburse the CWA in the amount of 25 percent of the gross recovery on a periodic basis to be determined by DMAHS.

(c)-(g) (No change.)

(h) This section shall apply to all pending and future recovery cases, except that [(b)6 above shall apply to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the CWA, whichever agency is handling the recovery.]:

1. The 25 percent incentive payments provided for in (b)4 and 5 above shall apply to all non-IEVS incorrect payment recoveries received by the CWA on or after July 1, 1993.

2. Paragraph (b)6 above applies to all IEVS-related recoveries received on or after July 1, 1989 by either DMAHS or the CWA, whichever agency is handling the recovery.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Pharmaceutical Services
Unit-Dose Drug Coverage
Proposed Amendments: N.J.A.C. 10:51-1.12, 2.11 and 4.13

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-6b(6); 30:4D-7, 7a, b and c; 30:4D-12; 30:4D-20, 22 and 24.

Proposal Number: PRN 1994-459.

Submit comments by September 14, 1994 to:
Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
Mail Code #26
CN 712
Trenton, New Jersey 08625-0712

The agency proposal follows:

Summary

These proposed amendments impact on both the New Jersey Medicaid (Title XIX) and PAAD programs. Currently, the New Jersey Medicaid program covers unit-dose packaged drugs provided to Medicaid recipients in an institutional setting. The New Jersey Medicaid program does not generally cover unit-dose packaged drugs provided to persons residing in the community. The proposed amendments will allow the New Jersey Division of Medical Assistance and Health Services to change its policy to allow coverage of unit-dose packaged drugs, if a unit-dose packaged drug is a unique product and is not otherwise available in the marketplace as a chemically-equivalent product. In these situations, the chemically equivalent product may be one of a different potency than the unit-dose packaged product. The Division does not intend to pay for a unit-dose packaged product, unless this is the only method of distribution of the drug available. The amendments apply to all persons residing in the community, including those residing in a boarding home or a residential care setting. The Division is adding the phrase "community-type setting" for clarification, to differentiate the requirements from those for nursing homes. The existing policies relating to the coverage of unit-dose packaged drugs for patients in nursing homes remain unchanged. In this type of setting, unit-dose packaged drugs are covered by the Medicaid and the PAAD programs.

Social Impact

There will be an impact on pharmacy providers because they will not be reimbursed for unit-dose packaging when a chemically equivalent product is available in non-unit-dose form, unless the product qualifies under N.J.A.C. 10:51-1.12(b)3i, 2.11(b)3i, and 4.13(b)4i.

There should be no impact on Medicaid or PAAD eligibles because they should still be able to get necessary pharmaceuticals.

Economic Impact

PAAD beneficiaries are still required to pay the $5.00 co-payment. There is no charge to the Medicaid recipients.

It is anticipated that there will be no change in overall drug costs in State Fiscal Year 1995 by implementing this amendment, although charges for specific prescriptions may be reduced.

The proposed amendment changes an existing Division policy which limits coverage of unit-dose packaged drugs. In addition, the amendment limits coverage of new prescription drugs which are only marketed in unit-dose packages by manufacturers. Pharmacy providers will have to be aware of this policy when dispensing unit-dose medication.

Regulatory Flexibility Analysis

A regulatory flexibility analysis is required. The providers affected by this amendment are small businesses, such as retail pharmacies, as defined in the New Jersey Administrative Procedure Act, N.J.S.A. 52:14B-16 et seq. Pharmacy providers are already required to maintain sufficient records to indicate the name of the recipient to whom the service was rendered, the date of service, etc. (N.J.S.A. 30:4D-12). These amendments do not change the basic compliance requirements.

However, the proposed amendments may require pharmacies to increase their notification of prescribers to request a prescription change. A hard copy prescription would be generated for each change approved. There might be some additional capital costs associated with this proposal, because the pharmacies may have to modify their recordkeeping procedures; however, no additional professional services will be required. Since Federal Medicaid regulations require services available to any individual be equal in amount, duration and scope (see 42 CFR 240(b)), this requirement shall apply equally to all providers regardless of size of business, and no differentiation can be made.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:51-1.12 Non-covered pharmaceutical services

(a) (No change.)

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1.-2. (No change.)

3. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting **or other community-type setting.**

i. [Exception: Drug products available only in a unit-dose package are covered.] **Drug products commercially available only as a unit-dose packaged product are covered when not otherwise marketed as a chemically equivalent product. The potency of equivalent products may or may not equal the potency of the unit-dose packaged product.**

(c) (No change.)

10:51-2.11 Non-covered pharmaceutical services

(a) (No change.)

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1.-2. (No change.)

3. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting **or other community-type setting.**

i. [Exception: Drug products available only in a unit-dose package are covered.] **Drug products commercially available only as a unit-dose packaged product are covered when not otherwise marketed as a chemically equivalent product. The potency of equivalent products may or may not equal the potency of the unit-dose packaged product.**

10:51-4.13 Non-covered pharmaceutical services

(a) (No change.)

(b) Otherwise reimbursable products shall be excluded from payment, under the following condition(s):

1. (No change.)

2. Covered diabetic testing materials which do not offer significant price and/or therapeutic advantage. The criteria shall be cost and improvement in accuracy over existing reimbursable products. Therapeutic advantage (in the case of diabetic testing materials improvement in accuracy) shall be determined by evaluation of literature and/or cost effectiveness data submitted in support of a request for admission of a diabetic testing material for inclusion in the list of reimbursable products; [and]

3. Manufacturers and distributors may request the review of a denial of reimbursement for products under this subsection by providing supportive information not previously submitted, within 30 days of the date of the denial. Agency decision after review of support material is final[.]; **and**

4. Drug products available in unit-dose packaging and dispensed to residents in a boarding home or residential care setting or other community-type setting.

i. Drug products commercially available only as a unit-dose packaged product are covered when not otherwise marketed as a chemically equivalent product. The potency of equivalent products may or may not equal the potency of the unit-dose packaged product.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Case Management Services
Billing for Case Management Services
Proposed Amendment: N.J.A.C. 10:73-1.1, 1.2, 2.1, 2.6, 2.8, 2.9, 2.10, 2.11, 2.12, 3.1 and 3.2

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-6b(17); 30:4D-7, 7a, b, and c; 30:4D-12; Section 1905(a)19, codified as 42 U.S.C. 1396d; and Section 1915g(1) and (2) of the Social Security Act codified as 42 U.S.C. 1396n.

Agency Control Number: 93-P-30.

Proposal Number: PRN 1994-429.

A copy of this proposal is available for review at the 21 county welfare agencies and the Medicaid District Offices.

Submit comments by September 14, 1994 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN 712
Mail Code #26
Trenton, New Jersey 08625-0712

The agency proposal follows:

Summary

The Department of Human Services (DHS) proposes to amend N.J.A.C. 10:73, which governs the provisions of case management services under the New Jersey Medicaid program. The objective of these amendments is threefold:

1. To change the billing unit for case management programs for mental health (CMP/MH) from one month to a "Unit of Service," 15 minute period. The basis for reimbursement will continue to be a fee-for-service;

2. To revise some of the requirements in order to accommodate the new billing methodology; and

3. To reword certain sections to clarify current Division policy.

Under the current methodology, providers bill for services rendered based on a monthly rate. This rate is an estimate of the average number of service hours required to provide case management services to chronically mentally ill individuals who are resistant to accessing appropriate medical, social and educational services.

At the end of the prior authorization period providers are required to reconcile the actual hours of service rendered against reimbursement received from the Medicaid program. In the event that the actual number of service hours rendered is less than the Medicaid reimbursement, providers are then required to remit the difference. This system of reconciliation and remittance has proven to be administratively burdensome to providers.

The proposed amendment seeks to simplify this billing procedure. It will require providers to bill for the number of units actually served at the time of billing, rather than receiving an estimated payment. In addition to reducing provider paperwork, this change will also adjust provider cash flow to more accurately reflect the actual amount of services that have been provided to clients. The proposed rule will not affect total reimbursement nor will it have an effect on service to clients. The amendment will simply more closely match reimbursements received to services rendered.

A summary of the proposed amendments follows:

1. N.J.A.C. 10:73-1.2: The definition of initial evaluation month is being replaced by initial evaluation services to reflect that providers will no longer bill on a monthly basis but on a date of service specific basis.

2. The definition of "unit of service" at N.J.A.C. 10:73-1.2 is also being revised to reflect that the new unit of service will be 15 minutes instead of an hour and providers will no longer be able to aggregate service contacts to meet the minimum requirements for a unit of service.

3. N.J.A.C. 10:73-2.1(b) is being amended to reflect that CMP/MH case management services are not available to individuals in some recently added waiver programs. This is consistent with previous policy that individuals under the waivers or other special programs already receive case management services.

4. N.J.A.C. 10:73-2.6(a): The responsibilities of the case manager supervisor are being deleted. These standards are established by the Division of Mental Health and Hospitals (DMH&H) and more appropriately belong in DMH&H regulations.

5. N.J.A.C. 10:73-2.6(b) will be recodified as N.J.A.C. 10:73-2.6(a) in view of the deletion of the subsection dealing with the responsibilities of the case management supervisor.

6. N.J.A.C. 10:73-2.6(b)2ii, 2iii, and 2iv are being changed to reflect the new billing methodology. This change also may allow liaison case managers some additional time to complete their responsibilities.

7. N.J.A.C. 10:73-2.8(a): The basis of payment is being amended to reflect the billing unit of 15 minutes rather than the current monthly billing procedure. This is consistent with the revised "unit of service" definition.

8. N.J.A.C. 10:73-2.8(a)1, 2, and 3 are being amended to replace the current five Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, with three new ones to accommodate the new billing procedure. The Administrative Code references for the case management codes remain the same even though the number of codes are decreased from five to three. These are technical changes to accommodate the new billing procedure. In addition, we are adding text to indicate that for this program a child is an individual under the age of 18.

9. N.J.A.C. 10:73-2.8(b) is being deleted since the policy reflecting monthly billing is being changed.

10. N.J.A.C. 10:73-2.8(b)1 is being recodified in view of deletion of paragraph (b) and is being amended to reflect the use of the new procedure codes and to more clearly state the policy that a provider may only render one type of case management service at a time.

11. N.J.A.C. 10:73-2.9(a) is being amended to reflect the new billing methodology.

12. N.J.A.C. 10:73-2.9(b): The word "month" is being changed to "services," consistent with the terminology in this proposal.

13. N.J.A.C. 10:73-2.9(b)1: The proposed amendment provides that billing for "units of service" are acceptable only when the client appears to meet the requirements for service, and continues the policy that initial evaluation services do not require prior authorization.

14. N.J.A.C. 10:73-2.9(b)2: The proposed change from initial evaluation month to initial evaluation services is consistent with the technical changes of the new billing methodology.

15. N.J.A.C. 10:73-2.9(b)3 and 3i: The proposed amendment to delete evaluation month and replace it with evaluation services is consistent with the new billing methodology being implemented. The change in policy requiring the provider to submit the prior authorization form within 45 days after rendering the initial reimbursable service, instead of the current one month following the month of initial services will allow in some cases additional time for providers to submit their prior authorization requests, but will shorten the time for others. Currently, providers may have from 31 to 60 days to submit the prior authorization request from the date of discharge. The change will make the time period in which a provider must submit a prior authorization request the same for each recipient.

16. N.J.A.C. 10:73-2.9(b)4 is being changed as the initial evaluation month is no longer applicable. The revised language reflects a reduction in time alloted for initial evaluation services. This reduction is based on administrative experience which has shown that initial evaluation services were being adequately supplied in less than the allowable time.

17. N.J.A.C. 10:73-2.10(b): The proposed amendment clarifies that risk levels are used to determine the number of "units of service" approved by DMH&H during a prior authorization period. This amendment clarifies current administrative policy and does not reflect a change in prior authorization policy.

18. N.J.A.C. 10:73-2.10(b)1 is being deleted in view of the language added at N.J.A.C. 10:73-2.10(b) and also in order to be consistent with this proposed billing methodology.

19. N.J.A.C. 10:73-2.10(b)2 is being recodified as paragraph (b)1 in view of deletion of the current paragraph (b)1.

20. N.J.A.C. 10:73-2.10(b)2i is being recodified as subparagraph (b)1i in view of the proposed deletion of the current paragraph (b)1 and is being amended to include nursing facility (NF) residents as ineligible for case management services. This is in view of the fact that NF reimbursement already includes needed medical/social services.

21. N.J.A.C. 10:73-2.10(b)2ii is being recodified as subparagraph (b)1ii in view of proposed deletion of the current paragraph (b)1. In addition, revisions are proposed to clarify that Division policy is applicable if the recipient is hospitalized or admitted to a nursing facility (NF), and that claims for services post-discharge will not be honored without prior authorization if any previous prior authorization has lapsed.

22. N.J.A.C. 10:73-2.10(b)3 is being amended to reflect that the current policies and procedures will continue to be applicable for services rendered prior to the implementation date of the new billing procedure. Providers will be notified via the rulemaking process and direct provider communication of the implementation date of the change in billing methodology.

23. N.J.A.C. 10:73-2.11(b) through (f) is being reordered in order to provide a clearer understanding of current Division policy regarding liaison case management. In addition, subsection (d) reflects a change in policy by revising the existing rule to change the time period the provider is allowed to render liaison case management services from the month of discharge plus the month following discharge to 60 calendar days. This allows the provider increased flexibility in allocating resources to render these needed services.

24. N.J.A.C. 10:73-2.11(g) is being recodified as subsection (h) and is being amended to reflect that the current reconciliation process is in effect for services rendered prior to the implementation of this proposal.

25. N.J.A.C. 10:73-2.12(a)1iv is being amended as the "units of service" definition and application to billing eliminates the requirement to specify the "aggregated, if needed" annotation in recordkeeping.

26. N.J.A.C. 10:73-3.2 is being amended to delete the old HCPCS codes and replace them with new HCPCS to accommodate the proposed billing procedure changes.

Social Impact

The proposed amendments to the existing rules will impact case management providers by reducing administrative burden. Likewise the administrative responsibilities of staff from the Divisions of Mental Health and Hospitals and Medical Assistance and Health Services will be reduced, in that the time spent analyzing reconciliations will be eliminated for future services. There will be no impact upon recipients of service, who are Medicaid eligible individuals in need of mental health services in the community.

Economic Impact

The proposed amendment will result in no significant economic impact upon recipients, providers or governmental agencies other than a reduction in administrative tasks. The proposed amendments are merely a change in methodology of billing for case management services, rather than a change in the amount of reimbursements received. The change in billing methodology should reduce the amount of time providers need to expend for billing purposes. Recipients will continue to receive these services free of charge.

Regulatory Flexibility Statement

The proposed amendments have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendments impose no new reporting, recordkeeping, or other compliance requirements on small businesses. Medicaid providers are required to keep records to indicate the date of service, nature of service, patient(s) treated, and other information prescribed by regulation (N.J.S.A. 30:4D-12). The proposed amendments govern providers of CMP/MH service which could be either non-profit social service agencies, other types of case management provider entities, or hospital corporations. There are approximately 46 case management providers, of which many may be considered small businesses as defined in the Act.

Under current rules, providers are required to bill for services at one of the several monthly rates. At the conclusion of a period, the provider is required to reconcile actual services provided on an hourly basis to the amounts billed on a monthly basis. The proposed amendment will change the billing period from one month to a 15 minute period of time. Providers will then be billing based upon actual services delivered, rather than an estimated average, and will, therefore, no longer be required to reconcile payments received to services rendered. The proposed amendments may result in a decreased regulatory burden on the provider.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:73-1.1 Purpose and scope

(a) This [manual] **chapter** outlines information about targeted case management services provided by approved New Jersey Medicaid Program providers.

1. There are various types of case management providers who will provide different types of case management services to targeted groups of Medicaid recipients, as allowed under Federal statute.

i. The first case management provider type described in this [manual] **chapter** is the Case Management Program/Mental Health (CMP/MH) provider (see N.J.A.C. 10:73-2). Other case management provider types may be added to the [manual] **chapter** as programs are developed.

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

10:73-1.2 Definitions

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

. . .

["Initial evaluation month" means the initial month in which services are provided to a client.]

"Initial evaluation services" means the initial contact, evaluation, completion of a risk assessment and initiation of services.

. . .

"Unit of service" under CMP/MH means a face-to-face contact with an enrolled client, or on behalf of an enrolled client, which lasts [one hour] **15 minutes** in duration. Travel time shall not be included as part of the face-to-face time. [Multiple contacts] **Contacts** of less than [one hour in duration may] **15 minutes can not** be aggregated to produce one unit of service.

10:73-2.1 Case Management Program/Mental Health (CMP/MH); general

(a) (No change.)

(b) Case management services are not available to recipients of the Medically Needy Program, except pregnant women, nor recipients served in the DMAHS' Home and Community Based Services Waiver Program, Model Waivers, DDD Waiver, **ABC Waiver, Traumatic Brain Injury Waiver,** or the Home Care Expansion Program.

1. (No change.)

10:73-2.6 Staff members of a CMP/MH provider; responsibilities

[(a) The following apply to the case management program supervisor:

1. Regarding his or her duties, the CMP/MH supervisor shall ensure the following:

i. Staff availability to meet the needs of program;

ii. Adequate levels of clinical staff supervision, skill development, and support;

iii. Development and appropriate documentation of the various CMP functions;

iv. Participation in the CMP quality assurance program;

v. Appropriate completion of and monitoring of affiliation agreements with other mental health, social and health services systems in conjunction with the systems coordinator, and

vi. Participation of the CMP in local mental health, health and human services planning activities.]

[(b)]**(a)** The following apply to the case manager (CM):

1. (No change.)

[3.]**2.** Regarding his or her duties, the CM providing liaison case management services shall:

i. (No change.)

ii. Develop discharge plans, in conjunction with other State or county psychiatric hospital or short term care facility treatment team members, for clients assessed as able or willing to access or engage in necessary community mental health services within [two calendar months] **60 days** after hospital discharge;

(1) (No change.)

iii. Ensure that planned community mental health and non-mental health service linkages occur for clients assessed as willing or able to link within [two calendar months] **60 days** after hospital discharge; and

iv. Monitor the clients linkage to the primary mental health provider for [two calendar months] **60 days** post discharge.

10:73-2.8 Basis of payment for CMP/MH services

(a) Reimbursement for services covered under the CMP/MH shall be determined by the Commissioner of the Department of Human Services. The provider of CMP/MH services shall be compensated on a [monthly] fee-for-service basis. Reimbursement is based upon HCPCS Codes as specified in N.J.A.C. 10:73-3.

1. The provider shall submit a claim form and identify the services performed by the use of procedure codes based on the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). [Five] **Three** HCPCS codes are assigned for the services provided under CMP/MH. If the services were provided to a child, the provider shall add a modifier (ZC) to the code to signify that the services were provided to a child. **For CMP/MH purposes, a child is an individual under the age of 18.**

2. The [five] **three** CMP/MH services that shall be identified on a claim form and submitted for reimbursement are:

i. Initial Evaluation Services.

[i.]**ii.** [Initial Evaluation Month;] **Clinical Case Management; and**

[ii. High Risk—Intensive Case Management involvement;

iii. At Risk—Supportive Case Management involvement;

iv. Low Risk—Maintenance Level Case Management involvement; and]

[v.]**iii.** Liaison Case Management.

3. For rules regarding the three case management services (initial evaluation [month], **clinical** case management [based on risk category], and liaison case management) see N.J.A.C. 2.9, 2.10 and 2.11[, respectively].

[(b) A provider may bill for only one case management service per calendar month; for example, for "initial evaluation month," or for one of the clinical case management's risk category services, or for liaison case management services.]

[1.](**b**) **A provider may only render one type of case management service to the same recipient within the same time period.** A recipient who receives case management services is entitled to receive other approved mental health services that are rendered by authorized providers.

(c)-(e) (No change.)

10:73-2.9 Procedures for providing initial risk assessment and evaluation for CMP/MH services

(a) Under clinical case management, the provider shall conduct an initial risk evaluation on a prospective CMP/MH client during the initial client contact(s) to determine the "risk category" using a form approved by the Division of Mental Health and Hospitals (DMH&H). If the prospective client is found to be eligible for CMP/MH services, he or she shall be assigned to a risk category described in (a)1-3, below. The provider shall immediately initiate a request for authorization to provide services beyond the [first calendar month] **initial evaluation services.**

1.-3. (No change.)

(b) The following apply to the initial evaluation [month] **services:**

1. In order to facilitate the provision of services to the client while the initial risk evaluation is completed and the request for prior authorization is being evaluated, the initial [contact(s) and services] **evaluation services** may be provided [for one calendar month] without **prior** authorization. [The initial evaluation, risk assessment, and initial services within a calendar month shall be billed as "Initial Evaluation" using the appropriate HCPCS Codes as listed at N.J.A.C. 10:73-3.] **Initial evaluation services shall only be provided to clients who appear to be in need of these services.**

2. A claim for [an] initial evaluation [month] **services,** [(any part of a calendar month)] may be submitted following [an] **the** initial assessment **process** performed on a prospective clinical case management client. [during the initial contacts. An initial] **Initial** evaluation [month] **services** may be billed once per recipient per provider. In the event a recipient changes providers, [the HCPCS code may be used for the initial month of service for] **initial evaluation services can be reimbursed to** the new provider.

i. [An initial] **Initial** evaluation [month visit] **services** may be billed by the same provider for the same recipient if there has been a lapse of more than 12 calendar months since the last case management service was provided.

3. During the initial evaluation [month] **services,** the provider should [initiate and] submit [the request for prior authorization to DMH&H for future service units] **form FD-365 (Prior Authorization Request) to DMH&H for future service units.**

i. The request for prior authorization must be received by DMH&H not later than [one calendar month from the initial evaluation month] **45 days after providing the first initial evaluation service for which reimbursement is requested.**

4. [A claim for an initial evaluation month will be reimbursed at the highest risk category rate within the CMP/MH rate structure. This will enable necessary services to be provided to the client.] **Reimbursement for initial evaluation services shall not exceed 20 units of service.**

10:73-2.10 Clinical case management services under CMP/MH

(a) (No change.)

(b) There are three levels (risk category) of clinical case management involvement based upon assessed risk of hospitalization, functional level, and willingness and/or ability to access needed services as defined by DMH&H. The three risk categories are: high risk, or intensive case management; at risk, or supportive case management; and low risk, or maintenance level case management (see N.J.A.C. 10:73-2.9). **The Risk Levels determine the number of units of service approved by DMH&H during a prior authorization period.**

[1. A minimum average "unit of service" shall be provided per month for each of the three codes for case management (high risk, at risk, and low risk) in order to earn reimbursement during the prior authorization period.

i. Initial evaluation month requires a minimum average of seven units of service per month.

ii. High risk (intensive case management involvement) requires a minimum average of seven units of service per month.

iii. At risk (supportive case management involvement) requires a minimum average of 3.5 units of service per month.

iv. Low risk (maintenance level case management involvement) requires a minimum average of two units of service per month.

v. Travel time shall not be included as part of the face-to-face time.

vi. Multiple contacts of less than one hour in duration may be aggregated to produce one unit of service.]

[2.]**1.** The following apply in recipient hospitalization **or residency in Nursing Facility (NF)** circumstances:

i. In the event a clinical case management recipient is hospitalized **or admitted to a NF** during a prior [authorized] **authorization** period, [for less than a full month, the case manager provider may bill for services for the entire month. The provider cannot bill for services for any month that the client remains in a hospital or an inpatient psychiatric program for an entire calendar month.] **the Medicaid program shall not be charged for CMP/MH services rendered during the hospitalization or residency in a NF.**

(1) (No change.)

(2) In the event a reassessment occurs following [a] hospitalization, **or residency in a NF,** appropriate documentation must be placed in the case file and, **if the risk level has changed,** a request for prior authorization for the new level of case management services must be forwarded to DMH&H, no later than 10 days after discharge. [The case manager cannot bill a new assessment month and, until a new risk level category is authorized,] **Until then, the case manager** must bill for continued services [and the post hospital discharge assessment] at the previously authorized risk [category] level.

ii. In the event a CMP/MH recipient's hospitalization **or residency in a NF** extends beyond a prior [authorized] **authorization** period, the provider shall request authorization from DMH&H to provide services post-discharge. Claims for [an] initial evaluation [month] **services** will not be processed if the recipient continues with the same provider. **Claims for services post-discharge will not be honored without prior authorization.**

[3.]**2. For services rendered prior to December 1, 1994,** [Each] **each** provider shall, within two months following the end of each prior authorization period, complete a reconciliation of services provided and payment received.

i.-iv. (No change.)

10:73-2.11 Liaison case management services under CMP/MH

(a) Services provided under [the] liaison case management include, but are not limited to:

1.-4. (No change.)

[(b) Liaison case management services shall be billed for not more than two consecutive months and shall not be billed in conjunction with any other CMP/MH service.

(c) Services listed in (a)1 to 4 above are reimbursed on a monthly fee-for-service and do not require prior authorization.

(d) Liaison case management services shall be billed for the month of discharge and the month following discharge from an acute care hospital, psychiatric hospital, or inpatient psychiatric program discharge.

(e) Liaison case management shall be billed for each discharge from a hospital if services are provided. The provider cannot bill for services for any month that the client remains in a hospital or an inpatient psychiatric program for an entire calendar month.]

(b) Services listed in (a)1 to 4 above are reimbursed on a fee-for-service basis, not to exceed 16 units.

(c) Liaison case management services do not require prior authorization.

(d) Liaison case management services may be provided within 60 days of discharge from a hospital or inpatient psychiatric program.

(e) Liaison case management services may be billed for each discharge from a hospital, if services are provided.

(f) Liaison case management shall not be billed in conjunction with any other CMP/MH service.

[(f)](**g**) (No change in text.)

[(g)](**h**) The reconciliation process described at N.J.A.C. 10:73[2.10(b)3]**2.10(b)2** with respect to clinical case management shall be required for liaison case management. The minimum average units of service to be provided are two units per month, post hospital discharge.

10:73-2.12 Recordkeeping for CMP/MH services

(a) Case management providers shall keep **such** individual records as are necessary to fully disclose the kind and extent of services provided to make sure **such** information **is** available as the DMA&HS or DMH&H, or its agents, may request.

1. The CMP/MH provider shall maintain the following data in support of all payment claims as required by the rules.

i.-iii. (No change.)

iv. The units of service [(aggregated, if needed)];

v.-vii. (No change.)

10:73-3.1 Introduction

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant to Medicaid case management services and must be used when filing a claim.

1.-3. (No change.)

4. HCPCS codes Z5000 through Z5004 shall not be billed for services rendered after December 1, 1994.

10:73-3.2 HCPCS codes for case management services

IND	HCPCS CODE	MOD	DESCRIPTION	MAXIMUM FEE ALLOWANCE
P	Z5000 through Z5004	ZC	(No change.)	
				Each Service Unit
	Z5005		**Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH) Adults**	**$ 12.50**
	Z5005	**ZC**	**Initial Evaluation Services, Case Management Program/Mental Health (CMP/MH), Children**	**$ 12.50**
	Z5006		**Clinical Case Management Program/ Mental Health (CMP/MH), Adults**	**$ 12.50**
	Z5006	**ZC**	**Clinical Case Management Program/ Mental Health (CMP/MH), Children**	**$ 12.50**
	Z5007		**Liaison Case Management Program/ Mental Health (CMP/MH) Adults**	**$ 12.50**
	Z5007	**ZC**	**Liaison Case Management Program/ Mental Health (CMP/MH), Children**	**$ 12.50**

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual
Child Support Hotline
Proposed Amendment: N.J.A.C. 10:81-11.15
Proposed New Rules: N.J.A.C. 10:81-11.6A and 11.6B

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 44:7-6 and 44:10-3; 45 C.F.R. 302.54(c)(1)(i) and (ii), 303.3(b)3 and 303.70(e).

Proposal Number: PRN 1994-460.

Submit comments by September 14, 1994 to:
Marion E. Reitz, Director
Division of Family Development
CN-716
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed new rule at N.J.A.C. 10:81-11.6A establishes the New Jersey Child Support Hotline and sets forth processing fees charged to the county welfare agencies (CWAs) for the use of the Child Support Hotline and the Federal Parent Locator Service (FPLS).

Proposed N.J.A.C. 10:81-11.6A(a) establishes the service of the New Jersey Child Support Hotline and requires that the CWAs be charged a fee for the use of this service. Federal regulations under 45 C.F.R. 302.54(b)(1) require that states send a monthly notice to all individuals who have assigned their support rights to the state, reporting the amount of child support collected for their case. Under 45 C.F.R. 302.54(c)(1)(i) and (ii), states are given the option to request a waiver to permit a state to provide a quarterly, rather than a monthly, notice if the state uses a toll-free automated voice response system which provides the information. New Jersey received Federal approval to implement this procedure and on May 11, 1992 the New Jersey Child Support Hotline was implemented on a Statewide basis.

The CWAs are charged for the hotline's 800 number, according to usage. The hotline will allow interested parties to obtain child support program information 24 hours a day, seven days a week in English or Spanish.

By dialing 1-800-621-KIDS, individuals can access the following information:

- Description of support services and how to apply;
- Information regarding emancipation, custody and visitation;
- Information regarding direct payments;
- Information regarding credit reporting;
- Information regarding the $50.00 disregard check;

- Tax offset information; and
- Check and payment information.

Callers may also leave a message for a specific worker.

Proposed N.J.A.C. 10:81-11.6B requires that the CWAs be charged a fee for the use of FPLS in specific child support cases. The FPLS is a computerized network, through which the states may request location information from Federal and state agencies to find absent parents. Fees have been implemented for the use of FPLS in child support cases in which an assignment of support rights to the State is not required, non-IV-D locate-only cases, parental kidnapping cases and child custody cases.

Prior to the implementation of new Federal regulations at 45 C.F.R. 303.70(e), FPLS fees were charged only for on-IV-D locate-only cases, parental kidnapping cases and child custody cases. Although recipients of Aid to Families with Dependent Children, IV-E foster care and Medicaid are excluded from paying any fees as support rights are assigned to the State in these cases, former recipients are not excluded from paying the fee. The funds generated by FPLS fees will be used to reimburse the Federal government for the expense of operating the FPLS. The CWAs will be billed, on a quarterly basis, according to the number of cases meeting the billing criteria submitted.

The proposed amendment at N.J.A.C. 10:81-11.15(d) establishes the "quick locate" process that may be used for those interstate cases in which information indicates that the absent parent could be in one of several states. In those interstate cases, a request for "quick locate" is made directly to the State Parent Locator of each of the states the absent parent could be in. Requests for "quick locate" do not constitute an official interstate case. Because the case is not an interstate case, the requesting state must take the "quick locate" action within the 75 calendar day time frame as required by Federal regulation at 45 C.F.R. 303.3(b)(3).

Social Impact

It is anticipated that the proposed N.J.A.C. 10:81-11.6A(a) regarding the hotline will have a positive social impact. Staff will no longer be inundated with telephone inquiries that the hotline can answer and child support information will be available to callers on a 24 hour basis.

Proposed N.J.A.C. 10:81-11.6A(b) regarding the charging of FPLS fees for those cases in which an assignment of support rights is not required, may meet with minimal resistance from the CWAs, since this is a service they received free of charge in the past. However, the implementation of the fee will not require modifications to the current procedure for the submittal of cases to FPLS, nor will it require addititional staff.

The proposed amendment at N.J.A.C. 10:81-11.15(d) regarding the "quick locate" process is expected to elicit a positive social reaction. Although using the "quick locate" process will require states to adhere to the 75 calendar day time frame from the point that location is determined necessary, it will also save child support workers time, because they will not have to complete all the paper work necessary to submit an official interstate case.

Economic Impact

It is anticipated that proposed N.J.A.C. 10:81-11.6A(a) regarding the hotline will have a positive economic impact. Although a fee will be assigned to the CWAs for the usage of the 24-hour hotline, staff time saved answering telephone inquiries can be used on enforcement, thereby, increasing child support collections.

The proposed requirement at N.J.A.C. 10:81-11.6A(b) regarding the charging of FPLS fees for those cases in which an assignment of support rights is not required, is expected to have minimal economic impact on the CWAs. Although they are being billed for a service they were not charged for in the past, a IV-D application is filed and an application fee is paid by the client for those cases in which an assignment of support rights is not required. The purpose of the IV-D application fee is to offset costs associated with case processing. In addition, the application fee was raised from $5.00 to $6.00 in December 1993 to cover any increased administrative costs related to case processing.

The proposed amendment at N.J.A.C. 10:81-11.15(d) regarding the "quick locate" process is expected to have a positive economic impact. It gives the requesting state the ability to initiate the location process in several states simultaneously without expending the time and energy it would take to officially establish an interstate case in another jurisdiction. This results in a savings of money through man hours and could lead to a more expedient successful location action and a more rapid establishment of the order.

Regulatory Flexibility Statement

The proposed amendment and new rules have been reviewed with regard to the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proposed amendment and new rule impose no reporting, recordkeeping or other compliance requirements on small businesses; therefore, a regulatory flexibility analysis is not required. The rules govern a public assistance program designed to certify eligibility for the Aid to Families With Dependent Children Program by a governmental agency rather than a private business establishment.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:81-11.6A Access to child support information

(a) The New Jersey Child Support Hotline's 800 number will allow interested parties to obtain child support information 24 hours a day, seven days a week, in English or Spanish.

1. By dialing 1-800-621-KIDS, individuals can access the following:

i. Description of support services and how to apply;

ii. Information regarding emancipation, custody and visitation;

iii. Information regarding direct payments;

iv. Information regarding credit reporting;

v. Information regarding the $50.00 disregard check;

vi. Tax offset information;

vii. Check and payment information; and

viii. A message voice mail system, whereby callers may leave a message for a specific worker.

10:81-11.6B County payment of fees for services

(a) Each CWA will be billed quarterly, according to its usage, for the service provided by the New Jersey Child Support Hotline's 800 number.

(b) Each county will be billed for submitting the following types of cases to the Federal Parent Locator Service (FPLS):

1. Child support cases in which an assignment of support rights to the State is not required;

2. Non-IV-D locate-only cases;

3. Parental kidnapping cases; or

4. Child custody cases.

(c) The counties will be billed quarterly, per case, at a rate determined by the Office of Child Support Enforcement of the United States Department of Health and Human Services. FPLS fees paid by the counties will be used to reimburse the Federal government for the expense of operating the FPLS.

10:81-11.15 State **PLS/**Federal Parent Locator Service (PLS)

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

(d) The "quick locate" process may be used for those interstate cases in which information indicates that the absent parent could be in one of several states.

1. A request for "quick locate" shall be made directly to the State Parent Locator of each of the states the absent parent could be in. The "quick locate" request shall not be made to another state's central registry.

2. A "quick locate" request does not constitute an official interstate case.

3. The "quick locate" request should be sent to the other state's SPLS in whatever format the requesting state chooses, with the exception of the Child Support Enforcement Interstate Transmittal (FSA-200). The FSA 200 shall not be used because it constitutes an official interstate request.

4. It is the responsibility of the requesting state to complete location activity within the 75 calendar day time frame as required by Federal regulations at 45 C.F.R. 303.3(b)(3).

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Initial Response

Proposed Amendments: N.J.A.C. 10:133A-1.7 and 1.10

Proposed Repeal and New Rule: N.J.A.C. 10:133A-1.9

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4C-4(h) and 9:6-8.15.

Proposal Number: PRN 1994-458.

Submit written comments by September 14, 1994 to:

Barbara Kraeger
Operational Policy and Manual Unit
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625

The agency proposal follows:

Summary

These Initial Response rules were originally developed by the Division as part of the Operations Policy to Rules (OPTR) project in order to subject Division policies which have wide-spread coverage, continuing effect or a substantial impact on the rights or legitimate interests of the regulated public to the rulemaking process. The OPTR project consists of the Division meeting with an advisory body, with members representing the affected public, private, non-profit groups and other government agencies.

These rules were among the first products of OPTR project. They became effective January 4, 1993, and operative July 1, 1993.

These proposed amendments and new rule have six primary purposes. Certain proposed provisions (proposed N.J.A.C. 10:133A-1.10(a)1 and 10) make the circumstances under which a response is begun immediately more specific. In proposed N.J.A.C. 10:133A-1.10(a)3 and 1.12(a), the circumstances under which the Division will or may act have been broadened.

The material being repealed from N.J.A.C. 10:133A-1.9(a) is now proposed as an amendment to N.J.A.C. 10:133A-1.7(a). The proposed N.J.A.C. 10:133A-1.9 is an expansion of the statement which was formerly N.J.A.C. 10:133A-1.10(a). The Division expanded this statement to clarify that any referral and application which require a child welfare services assessment (see N.J.A.C. 10:133C-3) or a child protective services investigation must have in-person contact between the client and the Division representative.

In addition, in proposed N.J.A.C. 10:133A-1.11, the Division wishes to combine the response category of within 24 hours into the category of within 72 hours. This step will allow the Division's caseworkers to do better planning for the responses they must make.

Proposed N.J.A.C. 10:133A-1.12(b) and (c) give new information about the response time frame for child welfare services referrals and applications. This material was inadvertently omitted from the original proposal.

The Division wishes to amend these rules to clarify that N.J.S.A. 9:6-1.1 and 9:6-8.21(c) are in compliance with Federal regulations pursuant to the Child Abuse Prevention and Treatment Act, 42 U.S.C. 5101 et seq. The Division has interpreted the New Jersey statute that prohibits the judicial finding of child neglect in cases where a child is receiving treatment by spiritual means alone through prayer, to not eliminate the Division's obligation to screen, respond to, investigate, and protect a child so referred.

The Division is adding statements at N.J.A.C. 10:133A-1.7(b) and 1.10(b)9 to clarify that the Division will screen and investigate these referrals in order to solidify the Division's compliance with Federal regulations, 45 CFR 1340 et seq.

Social Impact

These amendments and new rule should have only a limited effect on the regulated public. The Division will now be required to make an immediate response in situations where a child may need immediate medical treatment for any reason, not only as a result of abuse or neglect. This may result in the Division making more responses.

On the other hand, some clients may receive a more delayed response as the situations now requiring a response within 24 hours may now have a response within 72 hours. The Division will also be required to respond within 72 hours to other similar situations. This may or may not add new categories to which the Division must respond. The responses may or may not be quicker than at present. Situations of all types, not just sex abuse, may now be delayed more than 72 hours under certain conditions.

This proposal allows the Division representative the opportunity to prioritize the workload of in-coming applications. It allows the Division representative to plan the response to those families not in crisis by talking with supervisory staff about the response, making an appointment with the client, making collateral contacts and researching appropriate services within and outside the Division. This planning allows the Division to provide a helpful and efficient first personal contact between the Division and the applicant, while still requiring a timely response. N.J.A.C. 10:133A-1.12(b) also guarantees an immediate in-person response to a crisis situation **not** related to child abuse or neglect.

The Division does not anticipate any impact on the clients or applicants due to the additions regarding a child receiving treatment by spiritual means alone through prayer. The Division routinely screens and responds to these referrals.

Economic Impact

There will be no economic impact on clients or applicants.

The economic impact of adding the amendments about screening and responding to referrals of a child receiving treatment by spiritual means alone through prayer is to assure that the Division will continue to receive Federal funds, as authorized in the Child Abuse and Prevention and Treatment Act, 42 U.S.C. 5101 et seq. The Division received $519,213 in FY 1994, plus $74,487 through P.L. 98-457 (1984).

In addition, the Children's Trust Fund in New Jersey receives Federal funds, contingent upon New Jersey complying with Federal statutes. New Jersey received $150,142 from the Children's Trust Fund and $290,247 from the Criminal Justice Act.

While the Division may need to make an immediate or 24 to 72 hour response in two categories of referrals, the response time is lengthened for other types of referrals.

It is not possible to indicate how these minor changes will influence the Division's overall caseload size, budget or staffing needs.

Regulatory Flexibility Statement

Neither the Division nor the public who apply or are referred for services from the Division are considered small businesses under the terms of N.J.S.A. 52:14B-16 et seq., the Regulatory Flexibility Act. The proposed amendments do not impose reporting, record keeping or compliance requirements on small businesses. Therefore, a regulatory flexibility analysis is not necessary.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:133A-1.7 Screening of referrals and applications

(a) The Division representative shall screen each referral or application [to determine whether the referral or application for service is appropriate for the Division] **and determine, with supervisory approval, the most appropriate response. The most appropriate response shall be to:**

1. Conduct a child welfare services assessment to determine how or if the Division can provide child welfare services;

2. Conduct a child protective services investigation in order to determine whether a child is an abused or neglected child; or

3. Provide the applicant with information and referral to another resource and end the Division's involvement.

(b) The Division shall screen each referral which alleges that a child is or may be at risk because he or she is not receiving necessary medical attention because he or she in good faith is under treatment by spiritual means alone. While a child in this situation may not be considered to be abused or neglected, the Division shall conduct a protective services investigation.

[(b)](c) Screening shall be completed within three working days of receiving the referral unless the referral requires a more prompt response as stipulated in N.J.A.C. 10:133A-1.10[(b) and (c)] **and 1.11**.

10:133A-1.9 [Decision following screening] **Responding in person**

[(a) Following screening, the Division representative, with supervisory approval shall:

1. Conduct a child welfare services assessment to determine how or if the Division can provide child welfare services;

2. Conduct a child protective services investigation in order to determine whether a child is an abused or neglected child; or

3. Provide the applicant with information and referral to another resource and end the Division's involvement.]

When the Division determines that the Division will conduct a child welfare services assessment or a child protective services investigation, a Division representative shall respond in person.

10:133A-1.10 [Responding to referrals and applications] **Situations requiring immediate response**

[(a) The Division representative shall respond in person.

(b) The response shall begin immediately upon receipt of the referral when the allegation is that:

1. A child is currently being physically or sexually abused;

2. A child has been physically injured by abuse or neglect;]

[3.]**(a) The Division shall respond immediately upon receipt of the referral when the screening indicates that:**

1. A child has died under [suspicious] circumstances **that give the Division reason to believe that the child may have died due to abuse or neglect** and there [are] **may be** other children in the home;

2. A child has suffered physical harm or sexual trauma and physical evidence may be lost if not immediately and properly documented;

[4. A child has physical trauma or physical evidence of sexual interaction which may be lost if not documented immediately;]

[5.]**3.** A child may need immediate medical treatment [due to abuse or neglect] **and there is no one willing or able to take the necessary action**;

[6.]**4.** A child is without adult supervision and [is not] **may not be** competent to provide for his or her own care;

[7.]**5.** A child is in the hospital and in protective custody [in the hospital] **pursuant to N.J.S.A. 9:6-8.16**;

[8.]**6.** A child or family is in severe [psychological] crisis or actively calling for help which cannot be resolved over the telephone or by referral to another appropriate community resource;

[9.]**7.** The severity of a referral situation is in doubt; [or]

[10.]**8.** A foundling is discovered[, unless the child is already receiving appropriate medical care and the police are actively investigating.] **and the child is not receiving necessary medical attention and the police are not actively investigating;**

9. A child needs immediate medical treatment, but he or she is under treatment by spiritual means alone; or

10. A child has suffered serious physical harm or sexual trauma and there is reason to believe that a parent or guardian may have been responsible and the child's immediate safety needs to be assured.

[(c) The response shall begin within 24 hours of receiving a referral when the allegation is that:]

10:133A-1.11 Situations which indicate a response within 24 to 72 hours

(a) The Division may respond within 24 to 72 hours to referrals or applications which indicate the following situations:

1. A child has been physically abused in the past, evidence of the physical abuse is no longer present, and there is evidence that no abuse is likely to occur within [24] **72** hours because the perpetrator has no access to the victim; [or]

2. A foundling is already receiving appropriate medical care and the police are involved[.];

[(d) The response shall begin within 72 hours or, with the approval of the office manager, within three working days of receiving a referral unless an immediate or 24 hour response is required as outlined in (b) or (c), above when:]

[1.]**3.** The referral indicates present or past physical neglect;

[2.]**4.** The referral indicates emotional abuse or neglect;

[3.]**5.** The referral is from the Family Court, Crisis Intervention Unit or Court Intake;

[4.]**6.** The referral alleges domestic violence which is **not** threatening the **immediate** safety of the child; [or]

[5.]**7.** The referral of sexual abuse does not indicate current abuse or physical trauma, as stated in [(b) above] **N.J.A.C. 10:133A-1.10** or does not require an extension as described in [(e) below] **N.J.A.C. 10:133A-1.12**[.]**; or**

8. Other situations of a similarly serious nature.

10:133A-1.12 Situations requiring response within 10 days of referral

[(e) The response to an allegation of sexual abuse may begin]

(a) The Division may begin a response more than 72 hours after receiving a referral when a credible source, for example, the child's mental health practitioner, indicates that the child is not at risk and extending the time frame for response allows the Division representative to plan his or her response without compromising the child or the investigation. The Division representative shall document the reason for the extension of the time frame for response and obtain office manager approval. The response shall begin within 10 working days of the referral.

(b) In situations requiring child welfare services, the Division representative shall make personal contact with the client within 10 working days of receiving an application. If there is an urgent need for a service because the child or family is in crisis, the Division representative shall respond immediately in person.

(c) The Division shall respond to all situations listed in (b) above within 10 working days.

INSURANCE

(a)

THE COMMISSIONER

Notice of Extension of Public Comment Period Group Self-Insurance

Proposed Readoption: N.J.A.C. 11:15

Take notice that the Department of Insurance hereby extends the public comment period for the proposed readoption N.J.A.C. 11:15, Group Self-Insurance published in the New Jersey Register on June 20, 1994 at 26 N.J.R. 2518(a). The new public comment deadline will be September 9, 1994.

Submit written comments by September 9, 1994 to:

Donald Bryan
Acting Assistant Commissioner
Legislative and Regulatory Affairs
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625.

(b)

INDIVIDUAL HEALTH COVERAGE PROGRAM BOARD

Individual Health Coverage Program

Proposed Amendments: N.J.A.C. 11:20 Appendix and Exhibits A through F

Proposed New Rules: N.J.A.C. 11:20 Appendix Exhibits M, N, O and P

Authorized By: New Jersey Individual Health Coverage Program Board, Kevin O'Leary, Executive Director.

Authority: N.J.S.A. 17B:27A-2 et seq.

Proposal Number: PRN 1994-450.

Interested persons may testify with respect to proposed changes to the policy forms, Exhibits A through F, at a **public hearing** to be held on Thursday, July 21, 1994 at 10:00 A.M. at the New Jersey Department of Insurance, 2nd Floor, 20 West State Street, Trenton, New Jersey.

Submit written comments by July 28, 1994 to:
New Jersey Individual Health Coverage Program
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

These proposed amendments are being promulgated in accordance with P.L. 1993, c.164, section 8, which provides a special procedure whereby the Individual Health Coverage Program ("IHC") Board may adopt certain actions. Pursuant to this procedure, the Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and other interested persons who may request such notice.

Concurrently, the Board is required to forward the notice of the intended action to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. The Board must provide a minimum 20-day period for all interested persons to submit their written comments on the intended action to the Board. The Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the Board elects to adopt the action immediately upon the close of the comment period, it shall nevertheless respond to the comments timely submitted within a reasonable period of time thereafter. The Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include the list of commenters, their relevant comments, and the Board's responses.

The Board proposes amendments to the Basic plan policy form, policy forms B through E, and HMO policy form (N.J.A.C. 11:20 Appendix Exhibits A through F). While many of the proposed amendments are of a technical nature and will not affect benefits under the standard plans, other amendments will have the effect of increasing or decreasing specified benefits to insureds. These amendments are the first such changes to the policy forms since their original promulgation.

These changes are initiated by the Board to conform the policy forms as closely as possible to the Small Employer Health Benefits Program ("SEH") Board policy forms, to accommodate the Access Program, to conform the policy forms to changes in the law, to clarify the intent of the Board, to correct typographical or grammatical errors, and to make the policy forms internally consistent. Many of the changes are repeated in some or all of the policy forms.

Where appropriate, the Board is conforming the IHC policy forms to the corresponding plans promulgated by the SEH Program Board for the following reasons. First, the two statutes creating the IHC Program and the SEH Program were enacted together as part of a comprehensive reform of health insurance in the State, and it was intended that these two Boards work together in fulfilling their mandates. Second, by conforming the five standardized policies promulgated by the IHC Board to those promulgated by the SEH Board, the IHC Board will make comparison and analysis of the plans easier for consumers. Moreover, the proposed amendments reflect that, in some respects, the wording chosen by the SEH Board is more clear than that used in the IHC policy forms and that some of the policy decisions of the SEH Board are also applicable to health benefits plans issued pursuant to the IHC Program.

Toward the goal of conforming the policy forms as much as is appropriate to the SEH policy forms, in the definitional section of the policy forms, the proposed amendments change the definition of "Dependent" in all of the policy forms to refer to an unmarried child who is under age 19 instead of under age 20. This change represents a decrease in benefits. To conform with SEH policy forms and recognize the use of Preferred Provider Organizations ("PPOs"), the definition of "Reasonable and Customary," found in Exhibits A through E only, is amended to refer to the lesser of the usual or customary charge for the service as determined by the carrier based on a standard approved by the Board or a negotiated fee schedule. A definition of "Maintenance Drug" was added to the HMO policy form to allow an HMO choosing to use a $15.00 copayment for prescription drug coverage to distinguish maintenance drugs from non-maintenance drugs in determining applicable amounts of drugs to be furnished with each copayment.

With respect to the "Schedules of Benefits" provision in the policy forms, the proposed amendments amend Exhibit A to conform with the SEH policy form by changing the cash deductibles for inpatient services by deleting the $50.00 emergency room benefit and by providing emergency room benefit coverage only if the visit results in immediate hospitalization. The purpose of changing the emergency room benefit is to deter the unnecessary use of emergency rooms. With respect to Exhibits A through E, the proposed amendments clarify that co-insurance caps cannot be met with non-covered expenses, cash deductibles, or co-payments, and add that co-insurance cannot be met with co-insurance for the treatment of mental and nervous conditions and substance abuse. Removing the coinsurance paid for mental and nervous conditions and substance abuse from contributing to the coinsurance cap is a change in the design of the benefits.

With respect to the "Covered Charges" section of the policy forms, the proposed changes amend Exhibits A through E to conform with the SEH policy forms by changing the level of coverage for private room and board charges where a hospital does not have semi-private rooms available. The proposed changes amend Exhibits A through E by including coverage for home health care charges for diagnostic or therapeutic services which would have been covered under the policy if performed as inpatient hospital services. Also in Exhibits A through E, hospice care is expanded to recognize as a covered charge any palliative and supportive care to family members who are also covered persons. Also, in Exhibits B through E, the amendments remove the 180 day limit on coverage for hospice care charges. The proposed amendments to Exhibits A through E clarify that treatment of Wilm's Tumor is a covered charge.

The amendments to the "Covered Services" section of the HMO policy form would conform to the SEH Program's HMO policy form by adding coverage for medically necessary and appropriate replacement prosthetic devices and medical equipment, and for allogeneic and autologous bone marrow transplants.

With respect to the "Charges Covered With Special Limitations" section of Exhibits B through E, in order to conform with the SEH Program's policy forms, the proposed amendments add coverage for certain dental care and treatment, for certain private duty nursing care, for treatment for Temporomandibular Joint Disorder ("TMJ"), and for allogeneic and autologous bone marrow transplants. In addition, the proposed amendments would remove certain types of therapy services from the 30 visit per benefit period cap. The proposed amendments conform the Exhibits A through E to the SEH policy forms by clarifying that prosthetic devices may be covered where they are medically necessary and appropriate.

Also in order to conform Exhibits A through E to the SEH Program policy forms, the amendments create an optional "Alternative Treatment" section which permit the development of an agreed upon treatment plan in cases of catastrophic illness or injury as defined by this new section. Also in Exhibits A through E, the amendments create an optional section on "Centers of Excellence" which permit coverage for treatment by certain providers that have entered into an agreement with carriers to provide health benefits services for specific procedures.

With respect to the "Exclusions" section of the policy forms, the amendments will conform the Basic policy form with the Basic SEH policy form by removing fluoroscopy from the list of exclusions. The amendments conform Exhibits B through F with the SEH policy forms by removing fluoroscopy and TMJ from the list of exclusions and by altering the exclusions for dental care in Exhibits B through E. Optional exclusion language was added to the HMO policy form to allow an HMO that chooses to offer prescription drug coverage with a $15 copayment to define the amount of medication a covered person may receive per $15.00 payment.

The amendments would also add a section entitled "Right to Recovery—Third Party Liability" to all of the policy forms which would require an insured to reimburse his or her carrier for payments received from a third party for health benefits received as a result of the actions and/or deeds of that third party.

In addition to the changes listed above, all of which were initiated to conform the policy forms to the SEH policy forms, other changes were initiated to address changes in the law. In this regard, the amendments address the concerns of the Off Label Drug Use Act, P.L. 1993, c.321, by altering the definition of "experimental or investigational." Moreover, to conform to the requirements of the Access Program, the amendments alter the definition of "routine foot care" by deleting symptomatic complaints of the feet and clarify that the routine foot care exclusion does not include certain medically necessary and appropriate care.

These proposed amendments reflect the Board's decision to amend the policy forms independent of the choice or necessity to conform the plans with the SEH plans and other statutes. In this regard, in all of the policy forms, the Board proposes to change all personal pronouns from the masculine gender to both masculine and feminine personal pronouns. In all policy forms, the term and definition of "doctor" has been replaced by the term and definition "practitioner." This amendment is in recognition that services intended to be covered services under the plans may be provided by certain persons who are not medical doctors. As a clarification, the definitions of "hospice," "hospital," "mental health center" and "substance abuse center" are changed in all of the policy forms to include entities which are accredited or licensed by the State. The definition of "dependent" is changed to include persons residing in a foreign country for the purpose of attending an accredited school. The amendments alter the definition of "pre-existing condition" by adding that complications of a pregnancy, as defined by N.J.A.C. 11:1-43, are not considered pre-existing conditions and by expanding the waiver of the pre-existing condition limitation to apply to prior health benefits plans delivered or issued for delivery in the United States. For purposes of clarification, definitions of "care manager," "facility" and "referral" are added by the amendments.

The definition of "non-covered expenses" in Exhibits A through E is also amended by clarifying that utilization review penalties are non-covered expenses. In Exhibits A through E, the amendments clarify the utilization review procedures and change the penalty for unauthorized treatment from a complete denial of payment to a 50 percent reduction in payment.

In the "Eligibility" section of all the policy forms, the types of coverage were amended to clarify that coverage for multiple children residing within the same residence sharing a common legal guardian and for instances where there is a valid support order requiring health benefits coverage, even in cases when there is no adult covered are included in the parent and child type of coverage. Also for clarification purposes, a category for husband and wife coverage was added to the "Types of Coverage" Section of each of the policy forms.

In the "exclusions" section of all the policy forms, vision therapy, vision or visual acuity training, orthoptics and pleoptics are removed from the list of items which are not covered charges.

The paragraph entitled "Benefits From Other Plans" in the "Benefit Deductibles and Coinsurance" section of the policy forms is removed and the "Coordination of Benefits" section has been rewritten and retitled "Benefits from Other Plans." This retitled section provides that coverage under the standard policy forms is secondary to any other coverage an individual may have and that other coverage is primary. The amendments also provide that, because coverage under the standard policy forms is secondary, the premium paid by the insured is reduced to actuarially reflect the benefit reduction, provided that the insured: notifies the carrier of the fact that other coverage exists; and furnishes the carrier with an adequate description of the other coverage such that the carrier can judge the appropriate premium to be paid by the insured.

The proposed amendments amend the "General Provisions" section of the HMO policy from addressing non-compliance with medically necessary and appropriate treatment and refusal of treatment. The purpose of these changes is to address more completely the consequences of failing to comply with medically necessary and appropriate treatment and to provide a grievance procedure.

The proposed new Exhibits M and N adopt standard Point of Service ("POS") and Preferred Provider Organization ("PPO") provisions and Schedule of Benefits. These standard provisions and Schedule of Benefits create standardized language for carriers that wish to offer the Basic Plan and Plans B through E through these arrangements. These matters were previously not addressed in the policy forms.

Social Impact

The proposed amendments to Exhibits A through F are in some cases purely technical changes, in some cases substantive changes proposed at the Board's initiative or as the result of a dialogue with interested parties, and in some cases required by the passage of new laws. Most of the changes to the policy forms do not result in a change to the benefits in the plans; however, some changes may result in an increase or decrease in the benefits. Since some of these changes are substantive in nature and will alter coverage provided to insureds, these changes will affect insurers and health care providers, as well as insureds. In addition, clarifications to the policy forms should make the forms easier to read.

Economic Impact

The proposed amendments to the policy forms and the benefits offered therein may have an economic impact on individuals who enjoy greater benefits, or in some cases lesser benefits, under the amended provisions. The premium charged to individuals may, however, reflect the cost of such increases or decreases in benefits.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a Regulatory Flexibility Statement is not required. However, to the extent that any carrier might be considered a small business under the terms of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the following analysis would apply.

The proposed amendments to Exhibits A through F in the Appendix to N.J.A.C. 11:20 and the proposed new rules, Exhibits M through P to N.J.A.C. 11:20, will require carriers to amend all individual policy forms, and to conform their operations (sales and administration) to the new changes in the health benefits plans. There will be capital costs involved in such compliance, in terms of printing, systems programming, staff and agent training, etc., but it is unlikely that any carrier would have to contract for outside professional services in order to comply. All of the required changes to a carrier's business fall within the normal functions a carrier performs in complying with any State insurance law or regulation. An exemption from the policy form changes for certain small businesses would be inappropriate because such an exemption would permit the sale of non-conforming health benefits plans and could result in an uneven playing field for carriers in the individual market, both of which the Act attempts to prohibit.

Full text of the agency proposal follows (additions indicated in boldface **thus**; deletions indicated in cursive brackets {thus}):

APPENDIX

EXHIBIT A

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for a BASIC health benefits plan.

. . .

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. {But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.} We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom {we} We cover under this New Jersey BASIC Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page {21} **22.**

{All nouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.}

...

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[*CARE MANAGER.* An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

...

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age {20} **19**;
  (3) unmarried Child from age {20} **19** until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to be self-supported;
  (2) the Child's condition started before the {child} **Child** reached this Policy's age limit;
  (3) the Child became insured before the {child} **Child** reached this Policy's age limit, and stayed continuously insured until {he reached} **reaching** such limit; and
  (4) the Child depends on You for most of the Child's support and maintenance.

  In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{**DOCTOR.** A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where he practices; and
(b) provides medical services which are within the scope of his license or certificate and which are covered by this Policy.}

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below**.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

—The American Medical Association Drug Evaluations;
—The American Hospital Formulary Service Drug Information; or
—The United States Pharmacopeia Drug Information.
recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which:**
(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:
(a) approved for its stated purpose by Medicare {or}
(b) accredited for its stated purpose by the Joint Commission{.}; **or**
(c) accredited or licensed by the state of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:
(a) accredited as a hospital by the Joint Commission, {or}
(b) approved as a Hospital by Medicare{.} **or**
(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

...

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:
(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:
(a) accredited for its stated purpose by the Joint Commission; {or}
(b) approved for its stated purpose by Medicare{.}; **or**
(c) accredited or licensed by the state of New Jersey.

...

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, {and} Coinsurance **and Utilization Review Penalties** are also Non-covered Expenses.

...

PARTIAL HOSPITALIZATION. Day treatment services for Mental {and}**or** Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:
(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**
(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his **or her** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.**

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the {usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances} **[lesser of:**

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or,

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. **The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.**

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {dermatomas} **dermatomas,** keratosis, onychauxis, onychocryptosis{,} **or** tylomas {or symptomatic complaints of the feet}. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

...

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare{.}**; or**

(c) accredited or licensed by the state of New Jersey.

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by {Doctors} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner;**

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat{,} or promote recovery from{,} an Accidental Injury{, Mental or Nervous Condition} or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) PARENT AND CHILD(REN) COVERAGE—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefits coverage whether or not there is an adult who will be provided coverage.**

(d) ***HUSBAND AND WIFE*—coverage under this Policy for You and Your Spouse.**

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if {your} **Your** Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change {your} **Your** type of coverage. If {your} **Your** application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his **or her** eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your ependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM.

FACILITY BENEFIT—30 days Inpatient Hospital care.

FACILITY COINSURANCE—20% up to a maximum of $5000/Covered Person ({100%} **no benefit** after 30 days).

{DOCTORS'} ***PRACTITIONER'S*** **SERVICES COINSURANCE**—50% Inpatient and Outpatient (incl. Surgery, anesthesia, radiology and obstetrics).

NOTE: The Coinsurance Amounts cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Copayments**

CASH DEDUCTIBLES:

INPATIENT (separate)—{$1000/admission} **$250/day, $1,250**/per Period of Confinement/Covered Person; max. of two Inpatient Deductibles/Covered Person.

OTHER COVERED CHARGES—$250/Covered Person, $500/family.

{**EMERGENCY ROOM**}{—We will only pay $50/visit/Covered Person.}

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Primary Care Services are not subject to Deductibles and Coinsurance.

NOTE: OUR PAYMENTS WILL BE REDUCED {OR ELIMINATED} FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are shown in the Policy's Schedule of Premium Rates[:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For {Policyholder and Spouse} **Husband and Wife** ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy]. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: ***Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to you for those Charges.*** For Inpatient Hospital services and supplies and Rehabilitation Center services and supplies not immediately preceded by an Inpatient Hospital Stay{.} You must pay one Inpatient Deductible per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the {schedule} **Schedule of Benefits section of this Policy**. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. However, a Covered Person must satisfy two Inpatient Deductibles per Benefit Period. And all charges must be incurred while You are insured by this Policy. What We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family aggregate deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once {the} **a** family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the {Inpatient Hospital} **Facility** Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses{, Copayments and Deductibles}.

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period for the {Inpatient Hospital} **Facility** benefit. But We do not provide benefits for more than 30 Inpatient Hospital days per Benefit Period.

{THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT HOSPITAL DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.}

Deductible Credit: **For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.**

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Deductible Carryover: **There will be no carryover of Deductibles or Coinsurance into the next Benefit Period. However, a Covered Person will receive credit for any Inpatient Hospital Deductible satisfied during a Period of Confinement immediately preceding or continuing into a new Benefit Period.**

Payment Limits: We limit what We pay for certain types of charges.

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan which that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductible, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE {HOSPITAL ADMISSION} *UTILIZATION* REVIEW {PROGRAM IN} *SECTION OF* THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a {Doctor} **Practitioner** other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine {Doctor} **Practitioner**'s examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless {he} **the Child** is a Dependent.

Blood: We cover Inpatient blood transfusions only.

Daily Room and Board Limits:
(During a Period of Hospital Confinement)

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, {90%} **80%** of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

{Doctor} *Practitioner* Charges for Nonsurgical Care and Treatment: We only cover {Doctor} **Practitioner** charges for nonsurgical care and treatment of an Illness or Accidental Injury under Primary Care Services. See the "Schedule of Benefits" and "Primary Care Services" sections of this Policy.

{Doctor} *Practitioner* Charges for Surgery: We cover {Doctor} **Practitioner** charges for Surgery. But, We do not cover charges for cosmetic Surgery.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan on the basis of two Home Health Care days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as:

(a) Skilled Nursing Care furnished by or under the supervision of a registered Nurse;
(b) Therapy Services;
(c) Medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals; and
(g) **any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:**
   1. **Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.**
   2. **The services and supplies must be:**
      - **ordered by Your Practitioner;**
      - **included in the home health care plan; and**
      - **furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.**

But, payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your {Doctor} **Practitioner** must certify that home health care is needed in place of Inpatient care in a recognized {facility} **Facility**;
(b) the services and supplies must be: (a) ordered by Your {Doctor} **Practitioner**; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis;
(c) the home health care plan must be set up in writing by Your {Doctor} **Practitioner** within 14 days after home health care starts;
(d) each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program. **Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.**

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your {Doctor} **Practitioner** has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by {the} **Your** {Doctor} **Practitioner.**

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy on the basis of two Inpatient Hospice days in exchange for each Inpatient Hospital day relinquished. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your {Doctor} **Practitioner**;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; **or**

(e) services supplied to family members **who are not Covered Persons.** {other than the terminally Ill Covered Person; or

(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.}

Hospital Charges: We cover charges for Hospital semi-private room and board and Routine Nursing Care when it is provided to You by a Hospital on an Inpatient basis. But We limit what We pay as shown in the Schedule of Benefits. And We cover other Hospital services and supplies provided to You during the Inpatient confinement, including Surgery. However, We do not cover specialist consultations in a Hospital.

If You incur charges as an Inpatient in a Special Care Unit, We cover the charges the same way We cover charges for any Illness.

We also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. {And We cover emergency room treatment, subject to this Policy's Emergency Room Copayment Requirement}

We cover emergency room treatment only if such treatment subsequently results in Your admission to a Hospital.

Any charges in excess of the Hospital semi-private daily room and board limit are Non-Covered Expenses. This Policy contains penalties for noncompliance that will reduce what We pay for Hospital charges. See the section of this Policy called "Utilization Review" for details.

{**Outpatient Hospital Services:** We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy.}

Outpatient Hospital Services: **We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Chemotherapy, Radiation Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.**

. . .

Second Opinion Charges: We cover {Doctor} **Practitioner** charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If {you} **You** fail to obtain a second (or third) opinion when {we}**We** require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Center: Subject to Our advance written approval, when Skilled Nursing Care can take the place of Inpatient care, We cover such care furnished to You in a Skilled Nursing Center on the basis of two Skilled Nursing Center days in exchange for each Inpatient Hospital day relinquished. We cover all services or supplies, such as any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care {facility} **Facility**, provided such service is administered in a Skilled Nursing Center.

{**Therapy Services:** We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But we do not cover Dialysis Treatment.}

X-Rays and Laboratory Tests: We cover Inpatient and Outpatient x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, {or} birth defects in a covered Dependent Child **or complications of pregnancy as defined in N.J.A.C. 11:1-4.3.** We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan **delivered or issued for delivery in the United States**, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation **for a condition covered by that plan.**

Primary Care Services: We will cover up to $100 per Covered Person per Benefit Period, up to a maximum of $300 per family per Benefit Period, for routine physical examinations, Diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to Deductibles or Coinsurance.

Therapy Services: **We cover Inpatient and Outpatient Chemotherapy and Radiation Therapy. We cover other Therapy Services only on an Inpatient basis. But we do not cover Dialysis Treatment.**

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request {Our} *For* Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
{Human Organ/Bone Marrow Transplants}
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
{Transplants}
Tubal Transection and/or Ligation
Tympanoplasty
{Tympanostomy} **Tympanotomy** Tube

MEDICAL PROCEDURES

Lower Back Medical Care
{CAT Scan}
{Magnetic Resonance Imaging}

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT SCAN
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Home Health Care
Skilled Nursing Care
Hospice Care
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. **In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.**

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

{NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.}

STEP 2—Notice Requirements

For *Non-Medical Emergency* procedures, services and supplies listed above, You or Your Provider must *contact Us at least 3 days prior to treatment* or purchase.

For *Medical Emergency procedures, services and supplies* You or Your Provider must contact Us *within 48 hours or on the next business day,* from treatment whichever is later.

[For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL {MAKE NO PAYMENT} REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP {2} *3*—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step {3} **4** below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step {3} **4** below.

If the second opinion does not confirm the need for the procedure, We may require {you} **You** to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step {3} **4** below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP {3} *4*—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step {2} **3** above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, {WE WILL NOT MAKE} ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.**

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

{IX ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [Carrier].

Definitions

***"ALTERNATE TREATMENT"* means those services and supplies which meet both of the following tests:**

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

***"CATASTROPHIC ILLNESS OR INJURY"* means one of the following:**

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- **Us**
- **attending Practitioner**
- **Covered Person**
- **Covered Person's family, if any; and**

d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determines to be Experimental or Investigational.]

[X CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of the Policy. [However, the Utilization Review Features will not apply.]]

IX. *[XI]* EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

. . .

Facility charges (e.g., operating room, recovery room, use of equipment) whenb illed for by a Provider that is not an eligible facility **Facility.**

{Fluoroscopy or x-ray examinations without film.}

. . .

Local anesthesia charges billed separately by a {Doctor} **Practitioner** for surgery **he or she** performed on an Outpatient basis.

. . .

Routine Foot Care, **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service Medical Emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- —provided by or in any locale outside the United States, except in the case of a medical emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after {your} **Your** termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

. . .

X. *[XII.]* CLAIMS PROCEDURES

. . .

Claims Appeal: If We decline Your claim in whole or in part, We will {let You know} **send You an explanation of benefits** in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date {of the original declination} **after We receive Your request for review.**

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. *[XIII.]* {COORDINATION OF BENEFITS} *BENEFITS FROM OTHER PLANS*

{This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or

medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: **In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.**

XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a Third Party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a Third Party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the Third Party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the Third Party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a Third Party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.

{XIII.} *XIII. [XV.]* GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will {avoid} **void** the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

. . .

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your} **Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;

(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

...

{**OTHER PROVISIONS**

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.}

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible {facility} **Facility** or {Doctor} **Practitioner**, We will Determine to pay either You or the {facility} **Facility** or {Doctor} **Practitioner**.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

APPENDIX

EXHIBIT B

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan B.

...

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. {fBut, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.} We agree to pay benefits under the terms and provisions of this Policy.

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom {we} We cover under this New Jersey Individual Health Benefits Plan B.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under this Policy. Information about Your benefits begins on page 22.

{All pronouns in the singular used in this Policy will be deemed to include plural also, unless the context clearly indicates the contrary.}

...

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws; or

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[*CARE MANAGER.* An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or {your} **Your** legally adopted child, and Your step-child if the child depends on You for most of the child's support and maintenance, Your step-child. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or **his or her** Spouse is not a Child for purposes of eligibility for benefits under this Policy.

...

DEPENDENT.

(a) Your:
(1) Spouse;
(2) unmarried Child who is under age {20} **19**;
(3) unmarried Child from age {20} **19** until **the Child's** 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before {he} **the Child** reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until {he reached} **reaching** such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{**DOCTOR.** A medical practitioner We are required by law to recognize who:
(a) is properly licensed or certified to provide medical care under the laws of the state where he practices; and
(b) provides medical services which are within the scope of his license or certificate and which are covered by this Policy.}

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below**.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
—The American Medical Association Drug Evaluations;
—The American Hospital Formulary Service Drug Information; or
—The United States Pharmacopeia Drug Information.
recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which: (a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and (b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.**

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare; {or}
(b) accredited for its stated purpose by the Joint Commission{.}; **or**
(c) accredited or licensed by the state of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited as a hospital by the Joint Commission, {or}
(b) approved as a Hospital by Medicare{.}; **or**
(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

...

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;
(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;
(c) in accordance with accepted medical standards in the community at the time;
(d) not for Your convenience; and
(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}
(b) approved for its stated purpose by Medicare{.}; **or**
(c) accredited or licensed by the state of New Jersey.

...

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, {and} Coinsurance**, and Utilization Review Penalties** are also Non-covered Expenses.

...

PARTIAL HOSPITALIZATION. Day treatment services for Mental {and} **or** Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and
(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.**

...

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the {usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.} **[lesser of:**

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.

The Board may decide a standard for what is Reasonable and Customary under this Policy. **The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.**

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {de-

ratomas} **dermatomas**, keratosis, onychauxis, onychocryptosis{,} **or** tylomas {or symptomatic complaints of the feet}. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

...

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}
(b) approved for its stated purpose by Medicare{.}; **or**
(c) **accredited or licensed by the state of New Jersey.**

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by {Doctor} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner**;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat{,} or promote recovery from{,} an Accidental Injury{, Mental or Nervous Condition} or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.**
(d) ***HUSBAND AND WIFE*—coverage under this Policy for You and Your Spouse.**

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if {y} Your Primary Residence is in the State of New Jersey and You are not eligible for Medicaid, Medicare or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If Your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his/her eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his **or her** eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO PER LIFETIME MAXIMUM OF $1,000,000.

...

COINSURANCE CAP—After $3000/Covered Person, $6,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Copayments**

...

HOSPICE CARE—{180 days/Covered Person, if preapproved} **Unlimited days, if preapproved.**

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—**Subject to annual deductible and coinsurance.**

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. **Not subject to Deductible and Coinsurance.**

{SPINAL} **THERAPEUTIC MANIPULATIONS**—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services **except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).**

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED {OR ELIMINATED} FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

For Family Coverage ..... [$]

For {Policyholder and Spouse} **Husband and Wife** ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force.]Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy['s Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. For Inpatient Hospital services and Rehabilitation Center services not immediately preceded by an Inpatient Hospital Stay You must pay an Inpatient Deductible, up to two per Benefit Period, per Period of Confinement before We pay any benefits. For other Covered Charges, each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the {schedule} **Schedule of Benefits section of this Policy**. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. This does not apply to the Inpatient Hospital Deductible. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Inpatient Hospital Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses{, Copayments and Deductibles.} **and Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse.**

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet the Covered Person's own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period {for the Inpatient Hospital benefit}.

{THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD. HOWEVER, A COVERED PERSON WILL RECEIVE CREDIT FOR ANY INPATIENT HOSPITAL DEDUCTIBLE SATISFIED DURING A PERIOD OF CONFINEMENT PRECEDING A NEW BENEFIT PERIOD.}

Deductible Credit: **For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.**

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Deductible Carryover: **There will be no carryover of Deductibles or Coinsurance into the next Benefit Period. However, a Covered Person will receive credit for any Inpatient Hospital Deductible satisfied during a Period of Confinement immediately preceding and continuing into a new Benefit Period.**

Payment Limits: We limit what We pay for certain types of charges.

{Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment,

Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

Covered Charges for services and supplies rendered Inpatient are subject to the Inpatient Hospital Deductible.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a {Doctor} **Practitioner**. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible {facility} **Facility**, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a {Doctor} **Practitioner** other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine {Doctor} **Practitioner**'s examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the sections of this Policy called "Exclusions."

Daily room and board limits{:}

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, {90%} **80%** of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

{Doctor} *Practitioner* Charges for Nonsurgical Care and Treatment: We cover {Doctor} **Practitioner** charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

{Doctor} *Practitioner* Charges for Surgery: We cover {Doctor} **Practitioner** charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals{,} ; **and**
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
- **ordered by Your Practitioner;**
- **included in the home health care plan; and**
- **furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.**

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your {Doctor} **Practitioner** must certify that home health care is needed in place of Inpatient care in a recognized {facility} **Facility**.
(b) The services and supplies must be: (a) ordered by Your {Doctor} **Practitioner**; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your {Doctor} **Practitioner** within 14 days after home health care starts. And it must be reviewed by Your {Doctor} **Practitioner** at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program {, up to 180 days per Benefit Period}. **Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.**

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your {Doctor} **Practitioner** has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs {If Your} **if You** are terminally Ill. It must be set up in writing and reviewed periodically by Your {Doctor} **Practitioner**.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your {Doctor} **Practitioner**;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;

(d) treatment not included in the Hospice care plan; **or**
(e) services supplied to family members **who are not Covered Persons.** {other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.}

...

{**Outpatient Hospital Services:** We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Pre-admission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.}

Outpatient Hospital Services: **We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.**

Outpatient Surgical Center Charges: We cover charges made by an Outpatient Surgical Center in connection with covered Surgery.

Pre-Admission Testing Charges: We cover Pre-admission Testing needed for a planned Hospital admission or Surgery. We cover these tests if: (a) the tests are done within seven days of the planned admission or Surgery; and (b) the tests are accepted by the Hospital in place of the same post- admission tests.

We do not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in Your health.

Pregnancy: This Policy pays benefits for services in connection with pregnancies, including but not limited to: vaginal and cesarean delivery, and pre-natal and post-natal care. The charges We cover for a newborn Child are explained above.

Prescription Drugs: We cover charges for Prescription Drugs.

Rehabilitation Center: Subject to Our advance written approval, when rehabilitation care can take the place of Inpatient Hospital care, We cover such care furnished to You in a Rehabilitation Center. And We cover other Rehabilitation Center services and supplies provided to You during the Inpatient confinement.

Second Opinion Charges: We cover {Doctor} **Practitioner** charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If {you} **You** fail to obtain a second opinion when We require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care {facility} **Facility**, provided such service is administered in a Skilled Nursing Center.

{**Treatment for Therapeutic Manipulation:** We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.}

Treatment of Wilm's Tumor: **We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.**

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

***Dental Care and Treatment*—We cover:**

(a) the diagnosis and treatment of oral tumors and cysts; and
(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;
(b) the Injury was not caused, directly or indirectly by biting or chewing; and
(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental {and} **or** nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or {any properly licensed or certified Doctor} **Practitioner**{, psychologist or social worker}.

You must pay Coinsurance of 40% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, {or} birth defects in a covered Dependent Child **or complications of pregnancy as defined in N.J.A.C. 11:1-4.3.** We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan **delivered or issued for delivery in the United States,** with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month pre-existing condition limitation **for a condition covered by that plan.**

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: We only **cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the *Home Health Care Charges* section. Any other charges for private duty nursing care are a Non-Covered Charge.**

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, **unless they are Medically Necessary and Appropriate, We do not pay for** repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for {most} Therapy Services **other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.**

We cover Radiation Therapy, Chemotherapy, **Chelation, Dialysis and Respiration Therapy** as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: **We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.**

Transplants: {Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas.} **We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:**

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
- **Leukemia**
- **Lymphoma**
- **Neuroblastoma**
- **Aplastic Anemia**
- **Genetic Disorders**
  - **SCID**
  - **WISCOT Alldrich**
- **Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial.** ***Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Charges.***

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request {Our} *For* Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
{Tympanostomy} **Tympanotomy** Tube

MEDICAL PROCEDURES

Lower Back Medical Care
{CAT Scan}
{Magnetic Resonance Imaging}

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. **In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.**

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

{NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.}

STEP 2—Notice Requirements

For *Non-Medical Emergency* procedures, services and supplies listed above, You or Your Provider must *contact Us at least 3 days prior to treatment* or purchase.

For *Medical Emergency procedures, services and supplies* You or Your Provider must contact Us *within 48 hours or on the next business day,* from treatment whichever is later.

[For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact Us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL {MAKE NO PAYMENT} REDUCE ANY PAYMENT BY 50%.

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP {2} *3*—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step {3} 4 below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step {3} 4 below.

If the second opinion does not confirm the need for the procedure, We may require {you} **You** to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step {3} 4 below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP {3} *4*—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step {2} 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, {WE WILL NOT MAKE} ANY PAYMENT FOR FACILITY CHARGES *WILL BE REDUCED BY 50%.***

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

{IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

***"ALTERNATE TREATMENT"* means those services and supplies which meet both of the following tests:**

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

***"CATASTROPHIC ILLNESS OR INJURY"* means one of the following:**

a. head injury requiring an Inpatient stay

b. spinal cord Injury

c. severe burn over 20% or more of the body

d. multiple injuries due to an accident

e. premature birth

f. CVA or stroke

g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i. terminal Illness, with a prognosis of death within 6 months

j. Acquired Immune Deficiency Syndrome (AIDS)

k. chemical dependency

l. mental, nervous and psychoneurotic disorders

m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;

b. the Covered Person's attending Practitioner; and

c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;

b. course of treatment to accomplish the stated objectives;

c. the responsibility of each of the following parties in implementing the plan:

- **Us**
- **attending Practitioner**
- **Covered Person**
- **Covered Person's family, if any; and**

d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determines to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

IX. *[XI.]* EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Dental care or treatment{,} (including appliances) **except as otherwise specifically Covered.**

...

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible {facility} **Facility.**

{Fluoroscopy or x-ray examinations without film.}

...

Local anesthesia charges billed separately by a {Doctor} **Practitioner** for surgery **he or she** performed on an Outpatient basis.

...

Private-Duty Nursing, unless you have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Routine Foot Care, **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid.) This provision applies whether or not You assert Your rights to obtain such coverage or payment for services;
- —for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- —provided by or in any locale outside the United States, except in the case of a Medical Emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after {your} **Your** termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Special medical reports not directly related to treatment of the Covered Person (e.g. employment physicals, reports prepared in connection with litigation.)

Stand-by services required by a Provider.

Sterilization reversal.

Surgery, sex hormones, and related medical and psychiatric services to change Your sex; services and supplies arising from complications of sex transformation and treatment for gender identity disorders.

Telephone consultations, except as We may request.

TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

Vision therapy, vision or visual acuity training, orthoptics and pleoptics.

Vitamins and dietary supplements.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug used to eliminate baldness.

X. *[XII.]* CLAIMS PROCEDURES

...

Claims Appeal: If We decline Your claim in whole or in part, We will {let You know} **send You an explanation of benefits** in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date {of the original declination} **after We receive Your request for review.**

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. *[XIII.]* {COORDINATION OF BENEFITS} BENEFITS FROM OTHER PLANS

{This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: **In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.**

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a Third Party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a Third Party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the Third Party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the Third Party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a Third Party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the Third Party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the Third Party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a Third Party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no- fault tort liability of a Third Party.]

XII. *[XIV.] [XV.]* GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:
(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will {avoid} **void** the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

. . .

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your} **Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:
(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a Practitioner of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

...

{OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

We reserve the right to reasonably require that You be examined by a Doctor of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.}

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible {facility} **Facility** or {Doctor} **Practitioner**, We will Determine to pay either You or the {facility} **Facility** or {Doctor} **Practitioner**.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

APPENDIX

EXHIBIT C

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan C.

...

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom {we} We cover under this New Jersey Individual Health Benefits Plan C.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 22.

{All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.}

...

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;

(b) be staffed and equipped to give Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

...

[*CARE MANAGER.* An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

...

DEPENDENT.

(a) Your:
- (1) Spouse;
- (2) unmarried Child who is under age {20} **19**;
- (3) unmarried Child from age {20} **19** until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
- (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
- (1) the Child remains unmarried and unable to be self-supportive;
- (2) the Child's condition started before the Child reached this Policy's age limit;
- (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until {he reached} **reaching** such limit; and
- (4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{DOCTOR. A medical practitioner We are required by law to recognize who:
- (a) is properly licensed or certified to provide medical care under the laws of the state where he practices; and
- (b) provides medical services which are within the scope of his license or certificate and which are covered by this Policy.}

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:
- (a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
- (b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
- (c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below.**

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
- **—The American Medical Association Drug Evaluations;**
- **—The American Hospital Formulary Service Drug Information; or**
- **—The United States Pharmacopeia Drug Information.**

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which:**
- **(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and**
- **(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.**

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:

(a) approved for its stated purpose by Medicare; {or}

(b) accredited for its stated purpose by the Joint Commission[.]; **or**

(c) accredited or licensed by the state of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited as a hospital by the Joint Commission, or

(b) approved as a Hospital by Medicare{.}

(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

...

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}

(b) approved for its stated purpose by Medicare{.}; **or**

(c) accredited or licensed by the state of New Jersey.

...

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, {and} Coinsurance**, and Utilization Review Penalties** are also Non-covered Expenses.

...

PARTIAL HOSPITALIZATION. Day treatment services for Mental {and} **or** Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his/**her** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.**

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the {usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.} [less of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. **The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.**

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {deratomas} **dermatomas**, keratosis, onychauxis, onychocryptosis{,} **or** tylomas {or symptomatic complaints of the feet}. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

...

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}
(b) approved for its stated purpose by Medicare{.}; **or**
(c) accredited or licensed by the state of New Jersey.

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by {Doctor} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner**;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
(b) approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat{,} or promote recovery from{,} an Accidental Injury{, Mental or Nervous Condition} or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.**
(d) HUSBAND AND WIFE—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if {your}**Your** Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his **or her** eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his/**her** eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—30%

OTHER COVERED CHARGES—30% up to $2,500/Covered Person, $5,000/family.

COINSURANCE CAP—After $2,500/Covered Person, $5,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Copayments**

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—{180 days/Covered Person, if preapproved} **Unlimited days, if preapproved.**

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

{SPINAL} *THERAPEUTIC* MANIPULATIONS—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services **except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).**

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED {OR ELIMINATED} FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

For Family Coverage ..... [$]

For {Policyholder and Spouse} **Husband and Wife** ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated {on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits **(subject to the Family Deductible Cap as described below)** to You for those charges. The Deductibles are shown in the {schedule} **Schedule of Benefits section of this Policy**. The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by the You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses{, Copayments and Deductibles.} **and Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse.**

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his **or her** own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: **For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.**

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a {Doctor} **Practitioner**. But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible {facility} **Facility**, for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a {Doctor} **Practitioner** other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the Child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine {Doctor} **Practitioner**'s examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except asl imited in the section of the Policy called "Exclusions."

Daily room and board limits
During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, {90%} **80%** of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

{Doctor *Practitioner* Charges for Nonsurgical Care and Treatment: We cover {Doctor} **Practitioner** charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

{Doctor *Practitioner* Charges for Surgery: We cover {Doctor} **Practitioner** charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals{.}; **and**
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
- **ordered by Your Practitioner;**
- **included in the home health care plan; and**
- **furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.**

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your {Doctor} **Practitioner** must certify that home health care is needed in place of Inpatient care in a recognized {facility} **Facility**.
(b) The services and supplies must be: (a) ordered by Your {Doctor} **Practitioner**; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your {Doctor} **Practitioner** within 14 days after home health care starts. And it must be reviewed by Your {Doctor} **Practitioner** at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program {, up to 180 days per Benefit Period}. **Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.**

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your {Doctor} **Practitioner** has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If Your are terminally Ill. It must be set up in writing and reviewed periodically by Your {Doctor} **Practitioner**.

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your {Doctor} **Practitioner**;
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; or
(e) services supplied to family members **who are not Covered Persons**. {other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.}

. . .

{Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.}

Outpatient Hospital Services: **We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.**

. . .

Second Opinion Charges: We cover {Doctor} **Practitioner** charges for a second opinion and charges for related x-rays and tests when You

are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If {you} **You** fail to obtain a second opinion when we require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care {facility} **Facility**, provided such service is administered in a Skilled Nursing Center.

{**Treatment for Therapeutic Manipulation:** We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.}

Treatment of Wilm's Tumor: **We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.**

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment

We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and

(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;

(b) the Injury was not caused, directly or indirectly by biting or chewing; and

(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any {properly licensed or certified Doctor} **Practitioner**, psychologist or social worker.

You must pay Coinsurance of 30% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, {or} birth defects in a covered Dependent Child **or complications of pregnancy as defined in N.J.A.C. 11:1-4.3**. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan **delivered or issued for delivery in the United States**, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month {preexisting condition} **Pre-existing Condition** limitation **for a condition covered by that plan.**

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: **[Carrier] *only* covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part f a home health care plan, coordinated by a Home Health Agency, and covered under the *Home Health Care Charges* section. Any other charges for private duty nursing care are a Non-Covered Charge.**

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, **unless they are Medically Necessary and Appropriate. We do not pay for** repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for most Therapy Services **other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.**

We cover Radiation Therapy, {and} Chemotherapy, **Chelation, Dialysis and Respiration Therapy** as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

Treatment for Therapeutic Manipulation: **We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.**

Transplants: {Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas.} **We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:**

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy *only* for treatment of:
- **Leukemia**
- **Lymphoma**
- **Neuroblastoma**
- **Aplastic Anemia**
- **Genetic Disorders**
  - **SCID**
  - **WISCOT Alldrich**
- **Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. *Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Charges.***

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request {Our} *For* Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
{Tympanostomy} **Tympanotomy** Tube

MEDICAL PROCEDURES

Lower Back Medical Care
{CAT Scan}
{Magnetic Resonance Imaging}

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. **In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.**

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

{NOTE: For **Non-Medical Emergency** procedures, services and supplies listed above, You or Your Provider must **contact Us at least 3 days prior to treatment** or purchase. For **Medical Emergency procedures, services and supplies** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.}

STEP 2—Notice Requirements

For *Non-Medical Emergency* procedures, services and supplies listed above, You or Your Provider must *contact Us at least 3 days prior to treatment* or purchase.

For *Medical Emergency procedures, services and supplies* You or Your Provider must contact Us *within 48 hours or on the next business day,* from treatment whichever is later.

[For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL {MAKE NO PAYMENT} *REDUCE ANY PAYMENT BY 50%.***

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP {2} *3*—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step {3} **4** below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step {3} **4** below.

If the second opinion does not confirm the need for the procedure, We may require {you} **You** to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step {3} **4** below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP {3} *4*—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second

opinion process outlined in Step [2] 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, {WE WILL NOT MAKE}** ***ANY PAYMENT FOR FACILITY CHARGES WILL BE REDUCED BY 50%.***

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

"ALTERNATE TREATMENT" **means those services and supplies which meet both of the following tests:**

- **a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.**
- **b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.**

"CATASTROPHIC ILLNESS OR INJURY" **means one of the following:**

- **a. head injury requiring an Inpatient stay**
- **b. spinal cord Injury**
- **c. severe burn over 20% or more of the body**
- **d. multiple injuries due to an accident**
- **e. premature birth**
- **f. CVA or stroke**
- **g. congenital defect which severely impairs a bodily function**
- **h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure**
- **i. terminal Illness, with a prognosis of death within 6 months**
- **j. Acquired Immune Deficiency Syndrome (AIDS)**
- **k. chemical dependency**
- **l. mental, nervous and psychoneurotic disorders**
- **m. any other Illness or Injury determined by Us to be catastrophic.**

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by We through discussion and agreement with:

- **a. the Covered Person, or his or her legal guardian, if necessary;**
- **b. the Covered Person's attending Practitioner; and**
- **c. Us.**

The Alternate Treatment Plan includes:

- **a. treatment plan objectives;**
- **b. course of treatment to accomplish the stated objectives;**
- **c. the responsibility of each of the following parties in implementing the plan:**
  - **Us**
  - **attending Practitioner**
  - **Covered Person**
  - **Covered Person's family, if any; and**
- **d. estimated cost and savings.**

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determines to be Experimental or Investigational.]

[X CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

- **a. perform a Pre-Treatment Screening Evaluation; and**
- **b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.**

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

IX. *[XI.]* EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

. . .

Dental care or treatment{,} (including appliances) **except as otherwise specifically Covered.**

. . .

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible {facility} **Facility**

.

{Fluoroscopy or x-ray examinations without film.}

. . .

Local anesthesia charges billed separately by a {Doctor} **Practitioner** for surgery **he or she** performed on an Outpatient basis.

. . .

Private-Duty Nursing, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

. . .

Routine Foot Care, **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

- —eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;

—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
—provided by or in any locale outside the United States, except in the case of a Medical Emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after {your} **Your** termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

...

Telephone consultations, except as We may request.

{TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.}

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

{Vision therapy, vision or visual acuity training, orthoptics and pleoptics.}

...

X. *[XII.]* CLAIMS PROCEDURES

...

Claims Appeal: If We decline Your claim in whole or in part, We will {let You know} **send You an explanation of benefits** in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date {of the original declination} **after We receive Your request for review.**

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. *[XIII.]* {COORDINATION OF BENEFITS} *BENEFITS FROM OTHER PLANS*

{This provision applies to all Covered Charges under this Policy. [It does not apply to death, dismemberment, or loss of income benefits.]

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union

welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: **In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.**

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.]

XII. *[XIV.] [XV.]* GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will {avoid} **void** the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

. . .

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your}**Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

. . .

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a {Doctor} **Practitioner** of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

. . .

{OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.}

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible {facility} **Facility** or {Doctor} **Practitioner**, We will Determine to pay either You or the {facility} **Facility** or {Doctor} **Practitioner.**

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

APPENDIX

EXHIBIT D

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan D.

...

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page {-}**23**.

{All personal pronouns in singular in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.}

...

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;

(b) be staffed and equipped to give Medical Emergency care; and

(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;

(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

(c) it is approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[*CARE MANAGER.* An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or {your} **Your** legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom **You** have legal custody or legal guardianship is considered a Child under this Policy. (We may require that {you} **You** submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or **his or her** Spouse is not a Child for purposes of eligibility for benefits under this Policy.

...

DEPENDENT.

(a) Your:

(1) Spouse;

(2) unmarried Child who is under age {20} **19**;

(3) unmarried Child from age {20} **19** until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and

(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:

(1) the Child remains unmarried and unable to be self-supportive;

(2) the Child's condition started before the Child reached this Policy's age limit;

(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until {he reached} **reaching** such limit; and

(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{**DOCTOR.** A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where he practices; and

(b) provides medical services which are within the scope of his license or certificate and which are covered by this Policy.}

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or

(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below.**

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

—The American Medical Association Drug Evaluations;

—The American Hospital Formulary Service Drug Information; or

—The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which:**

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare {or};

(b) accredited for its stated purpose by the Joint Commission{.}; **or**

(c) accredited or licensed by the state of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is either:

(a) accredited as a hospital by the Joint Commission, or

(b) approved as a Hospital by Medicare{.} **or**

(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

...

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}

(b) approved for its stated purpose by Medicare{.}; **or**

(c) accredited or licensed by the state of New Jersey.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental {and} **or** Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK PROVIDER. A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, {and} Coinsurance, **and Utilization Review Penalties** are also Non-covered Expenses.

...

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**

(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and

(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his **or her** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.**

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the {usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.} [lesser of:

(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board [; or

(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. **The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.**

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {deratomas} **dermatomas**, keratosis, onychauxis, onychocryptosis{,} **or** tylomas {or symptomatic complaints of the feet}. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

...

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}

(b) approved for its stated purpose by Medicare{.} **or**

(c) accredited or licensed by the state of New Jersey.

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by {Doctor} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner**;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat{,} or promote recovery from{,} an Accidental Injury{, Mental or Nervous Condition} or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage.**

(d) ***HUSBAND AND WIFE*—coverage under this Policy for You and Your Spouse.**

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if {your} **Your** Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his **or her** eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of **his or her** eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—20% up to $2,000/Covered Person, $4,000/family.

COINSURANCE CAP—After $2,000/Covered Person, $4,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Copayments**

CASH DEDUCTIBLE—[$250] [$500] [$1,000]/Covered Person, [$500] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE—{180 days/Covered Person, if preapproved} **Unlimited days, if preapproved.**

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

***PRESCRIPTION DRUGS*—Subject to annual deductible and coinsurance.**

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

{SPINAL} ***THERAPEUTIC*** **MANIPULATIONS**—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services **except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).**

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED {OR ELIMINATED} FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]

For Parent and Child(ren) Coverage ..... [$]

For Family Coverage ..... [$]

For {Policyholder and Spouse} **Husband and Wife** ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated [on the first page of the Policy.] You may pay each Premium other than the first within 31 days of the [Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates]. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges **(subject to the Family Deductible Cap as described below).** The Deductibles are shown in the {schedule} **Schedule of Benefits section of this Policy.** The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by the You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses{, Copayments and Deductibles} **and Coinsurance for the treatment of Mental or Nervous Conditions and Substance Abuse.**

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his/**her** own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: **For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.**

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

{**Benefits From Other Plans:** When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a {Doctor} **Practitioner.** But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible {facility} **Facility,** for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a {Doctor} **Practitioner** other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine {Doctor} **Practitioner**'s examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the Child is a Dependent.

Blood: We cover blood, blood products and blood transfusions except as limited in the section of this Policy called "Exclusions."

Daily room and board limits{:}

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, {90%} **80%** of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

{Doctor} *Practitioner* Charges for Nonsurgical Care and Treatment: We cover {Doctor} **Practitioner** charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

{Doctor} *Practitioner* Charges for Surgery: We cover {Doctor} **Practitioner** charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;
(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals{.} ; **and**
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
• ordered by Your Practitioner;
• included in the home health care plan; and
• furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your {Doctor} **Practitioner** must certify that home health care is needed in place of Inpatient care in a recognized {facility} **Facility**.
(b) The services and supplies must be: (a) ordered by Your {Doctor} **Practitioner**; (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part- time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your {Doctor} **Practitioner** within 14 days after home health care starts. And it must be reviewed by Your {Doctor} **Practitioner** at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program {, up to 180 days per Benefit Period}. **Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.**

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your {Doctor} **Practitioner** has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You{r} are terminally Ill. It must be set up in writing and reviewed periodically by Your {Doctor} **Practitioner.**

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your {Doctor} **Practitioner;**
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; **or**
(e) services supplied to family members **who are not Covered Persons.** {other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.}

...

{Outpatient Hospital Services: We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Preadmission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.}

Outpatient Hospital Services: **We cover Outpatient Hospital services and supplies provided in connection with covered Hospital Admission Review and Preadmission Testing, Surgery, Therapy Services and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.**

...

Second Opinion Charges: We cover {Doctor} **Practitioner** charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If {you} **You** fail to obtain a second opinion when {we} **We** require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care {facility} **Facility**, provided such service is administered in a Skilled Nursing Center.

{Treatment for Therapeutic Manipulation: We limit what we cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.}

Treatment of Wilm's Tumor: **We pay covered charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat covered charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.**

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

Dental Care and Treatment

We cover:

(a) the diagnosis and treatment of oral tumors and cysts; and

(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:

(a) the Injury occurs while You are insured under any health benefit plan;

(b) the Injury was not caused, directly or indirectly by biting or chewing; and

(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental {and} **or** nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse
Center, or any properly licensed or certified {Doctor} **Practitioner**, psychologist or social worker.

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, {or} birth defects in a covered Dependent Child **or complications of pregnancy as defined in N.J.A.C. 11:1-4.3**. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan **delivered or issued for delivery in the United States**, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation **for a condition covered by that plan.**

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

***Private Duty Nursing Care:* We *only* cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the *Home Health Care Charges* section. Any other charges for private duty nursing care are a Non-Covered Charge.**

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, **unless they are Medically Necessary and Appropriate, We do not pay for** repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for {most} Therapy Services **other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.**

We cover Radiation Therapy, {and} Chemotherapy, **Chelation, Dialysis and Respiration Therapy** as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ)

We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.

***Treatment for Therapeutic Manipulation:* We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.**

Transplants: {Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas.} **We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:**

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:
- **Leukemia**
- **Lymphoma**
- **Neuroblastoma**
- **Aplastic Anemia**
- **Genetic Disorders**
  - **SCID**
  - **WISCOT Alldrich**
- **Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. *Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Charges.***

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request {Our} *For* Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, **You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.**

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft

Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
{Tympanostomy} **Tympanotomy** Tube

MEDICAL PROCEDURES

Lower Back Medical Care
{CAT Scan}
{Magnetic Resonance Imaging}

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. **In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.**

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

{NOTE: For ***Non-Medical Emergency*** procedures, services and supplies listed above, You or Your Provider ***must contact Us at least 3 days prior to treatment*** or purchase. For ***Medical Emergency procedures, services and supplies*** You or Your Provider must contact Us **within 48 hours or on the next business day,** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.}

STEP 2—Notice Requirements

For *Non-Medical Emergency* procedures, services and supplies listed above, You or Your Provider must *contact Us at least 3 days prior to treatment* or purchase.

For *Medical Emergency procedures, services and supplies* You or Your Provider must contact Us *within 48 hours or on the next business day,* from treatment whichever is later.

[For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL {MAKE NO PAYMENT} REDUCE ANY PAYMENT BY 50%.**

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP {2} *3*—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step {3} **4** below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step {3} **4** below.

If the second opinion does not confirm the need for the procedure, We may require {you} **You** to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step {3} **4** below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP {3} *4*—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step [2] **3** above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO *NOT* AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, {WE WILL *NOT* MAKE} ANY PAYMENT FOR FACILITY CHARGES *WILL BE REDUCED BY 50%.***

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

***"ALTERNATE TREATMENT"* means those services and supplies which meet both of the following tests:**

a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"CATASTROPHIC ILLNESS OR INJURY" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by Us to be catastrophic.

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by Us through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- **Us**
- **attending Practitioner**
- **Covered Person**
- **Covered Person's family, if any; and**

d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determines to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

IX. *[XI.]* EXCLUSIONS

THE FOLLOWING ARE NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Dental care or treatment{,} (including appliances) **except as otherwise specifically Covered.**

...

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible {facility} **Facility.**

{Fluoroscopy or x-ray examinations without film.}

...

Local anesthesia charges billed separately by a {Doctor} **Practitioner** for surgery he **or she** performed on an Outpatient basis.

...

Private-Duty Nursing, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Routine Foot Care, **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
—for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;
—for which You would not have been charged if You did not have health care coverage;
—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
—for which the Provider has not received a certificate of need or such other approvals as are required by law;
—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
—in an amount greater than a Reasonable and Customary charge;
—needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
—provided by or in any locale outside the United States, except in the case of a Medical Emergency;
—provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
—provided by a social worker, except as otherwise stated in this Policy;
—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
—rendered prior to Your Effective Date of coverage or after {your} **Your** termination date of coverage under this Policy;
—which are specifically limited or excluded elsewhere in this Policy;
—which are not Medically Necessary and Appropriate; or
—which You are not legally obligated to pay.

...

{TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.}

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

{Vision therapy, vision or visual acuity training, orthoptics and pleoptics.}

...

X. *[XII.]* CLAIMS PROCEDURES

...

Claims Appeal: If We decline Your claim in whole or in part, We will {let You know} **send You an explanation of benefits** in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:

(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;
(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date {of the original declination} **after We receive Your request for review.**

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. *[XIII.]* {COORDINATION OF BENEFITS} *BENEFITS FROM OTHER PLANS*

{This provision applies to all Covered Charges under this Policy. [It does not apply to death, dismemberment, or loss of income benefits.]

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action.

When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

***Our Right To Certain Information:* In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.**

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata ex-

penses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.]

XII. *[XIV.] [XV.]* GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will {avoid} **void** the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

. . .

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your} **Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

. . .

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a {Doctor} **Practitioner** of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

. . .

{OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.}

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible {facility} **Facility** or {Doctor} **Practitioner**, We will Determine to pay either You or the {facility} **Facility** or {Doctor} **Practitioner**.

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

. . .

APPENDIX
EXHIBIT E

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the individual health benefits Plan E.

. . .

Premiums. We may only change the Premium schedule for this Policy if We change the Premium schedule for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom {we} **We** over under this New Jersey Individual Health Benefits Plan E.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand Your benefits under the Policy. Information about Your benefits begins on page 23.

{All personal pronouns in the singular used in this Policy will be deemed to include the plural also, unless the context clearly indicates the contrary.}

...

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if:

(a) it carries out its stated purpose under all relevant state and local laws;
(b) it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) it is approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[*CARE MANAGER.* An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of treatment.]

CARE PREAPPROVAL. The authorization of coverage for benefits under this Policy which You obtain from Us prior to incurring medical services or supplies.

CASH DEDUCTIBLE (OR DEDUCTIBLE). The amount of Covered Charges that You must pay before this Policy pays any benefits for such charges. See the "Cash Deductible" provision of this Policy for details.

CHILD. Your own issue or Your legally adopted child, and Your stepchild if the child depends on You for most of the child's support and maintenance. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom You have legal custody or legal guardianship is considered a Child under this Policy. (We may require that You submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or **his or her** Spouse is not a Child for purposes of eligibility for benefits under this Policy.

...

DEPENDENT.

(a) Your:
(1) Spouse;
(2) unmarried Child who is under age {20} **19**;
(3) unmarried Child from age {20} **19** until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask for periodic proof that the Child is so enrolled); and
(4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
(1) the Child remains unmarried and unable to be self-supportive;
(2) the Child's condition started before the Child reached this Policy's age limit;
(3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until {he reached} **reaching** such limit; and
(4) the Child depends on You for most of the Child's support and maintenance.

In order for the Child to remain a Dependent, You must send us written proof that the Child is handicapped and depends on You for most of his support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed forces.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{**DOCTOR.** A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where he practices; and
(b) provides medical services which are within the scope of his license or certificate and which are covered by this Policy.}

...

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including

treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below.**

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

—The American Medical Association Drug Evaluations;

—The American Hospital Formulary Service Drug Information; or

—The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which:**

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is either:

(a) approved for its stated purpose by Medicare {; or},

(b) accredited for its stated purpose by the Joint Commission{.}, **or**

(c) accredited or licensed by the State of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. We will recognize it if it carries out it stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited as a hospital by the Joint Commission, {or}

(b) approved as a Hospital by Medicare{.}, **or**

(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

...

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission{; or};

(b) approved for its stated purpose by Medicare{.}; **or**

(c) accredited or licensed by the state of New Jersey.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental {and} **or** Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[**NETWORK PROVIDER.** A Provider which has an agreement with Us to accept Our Allowance plus amounts You are required to pay as payment in full for Covered Charges.]

NON-COVERED EXPENSES. Charges which do not meet Our definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Expenses. Cash Deductibles, Copayments, {and} Coinsurance**, and Utilization Review Penalties** are also Non-covered Expenses.

...

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**
(a) is properly licensed or certified to provide care under the laws of the state where he or she practices; and
(b) provides services which are within the scope of his or her license or certificate and which are covered by this Policy.

PREMIUM. The periodic charges due under this Policy which the Policyholder must pay to maintain this Policy in effect.

PRE-ADMISSION TESTING. Consultations, X-ray and laboratory tests performed no more than seven days before a planned Hospital admission or Surgery.

See the sections of this Policy called "Request for Care Preapproval" and "Obtain Hospital Admission Review" for details on other important aspects of Your benefits.

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:
(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or
(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his **or her** coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations.**

See the section of this Policy called "Pre-Existing Condition Limitations" for details on how this Policy limits the benefits for Pre-Existing Conditions.

...

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the {usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. When We decide what is reasonable, We look at Your condition and how severe it is. We also look at special circumstances.} **[lesser of:**
(a) the] usual or customary charge for the service or supply as determined by Us based on a standard approved by the Board[; or
(b) the negotiated fee.]

The Board may decide a standard for what is Reasonable and Customary under this Policy. **The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.**

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities{; or},
(b) approved for its stated purpose by Medicare{.}, **or**
(c) accredited or licensed by the state of New Jersey.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {deratomas} **dermatomas**, keratosis, onychauxis, onychocryptosis{,} **or** tylomas {or symptomatic complaints of the feet}. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by the Joint Commission; or
(b) approved for its stated purpose by Medicare.

...

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:
(a) accredited for its stated purpose by the Joint Commission; {or}
(b) approved for its stated purpose by Medicare{.}; **or**
(c) accredited or licensed by the state of New Jersey.

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:
(a) be staffed by {Doctor} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner**;
(b) have permanent operating and recovery rooms;
(c) be staffed and equipped to give emergency care; and
(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

We will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care{; or},
(b) approved for its stated purpose by Medicare{.} **or**
(c) accredited or licensed by the state of New Jersey.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat{,} or promote recovery from{,} an Accidental Injury{, Mental or Nervous Condition} or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.
(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependents.
(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.**
(d) *HUSBAND AND WIFE*—coverage under this Policy for You and Your Spouse.

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if {your} **Your** Primary Residence is in the State of New Jersey and You are not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.
(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan that provides the same or similar coverage, or who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, Your Spouse will be covered from the date of his **or her** eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Charges incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of his eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the Benefit Month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF BENEFITS

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND ARE DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO AN UNLIMITED PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—25%.

OTHER COVERED CHARGES—10% up to $1,500/Covered Person, $3,000/family.

COINSURANCE CAP—After $1,500/Covered Person, $3,000/family, We pay 100%.

NOTE: The Coinsurance Caps cannot be met with:

- **Non-Covered Expenses**
- **Cash Deductibles**
- **Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Copayments**

CASH DEDUCTIBLE—[$150] [$500] [$1,000]/Covered Person, [$300] [$1,000] [$2,000]/family.

EMERGENCY ROOM COPAYMENT—$50/visit/Covered Person credited toward Inpatient admission within 24 hours.

HOME HEALTH CARE—Unlimited days, if preapproved.

HOSPICE CARE— Unlimited days, if preapproved.

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFIT MAXIMUMS—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

Per Lifetime Maximum of $25,000 combined Inpatient and Outpatient.

***PRESCRIPTION DRUGS*—Subject to annual deductible and coinsurance.**

PRIMARY CARE SERVICES—$300/Covered Person (except newborns). Newborns: $500 for their first year of life. Not subject to Deductible and Coinsurance.

SKILLED NURSING CARE—120 days of confinement/Covered Person, if preapproved.

{**SPINAL**} ***THERAPEUTIC*** **MANIPULATIONS**—30 visits/Covered Person.

THERAPY SERVICES—30 visits/Covered Person/Therapy Services **except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).**

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED {OR ELIMINATED} FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.

IV. PREMIUM RATES AND PROVISIONS

[The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are:

For Single Coverage ..... [$]
For Parent and Child(ren) Coverage ..... [$]
For Family Coverage ..... [$]
For {Policyholder and Spouse} **Husband and Wife** ..... [$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premiums."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Covered Person whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Covered Person that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Covered Person's coverage has ended.

(b) the amount of any claims paid to You or Your Provider for Your claims or to a Member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date [stated on the first page of the Policy[. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law[.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Policy's [Schedule of Premium Rates[. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;
(b) any date that the extent or nature of the risk under the Policy is changed:
  (1) by amendment of the Policy; or
  (2) by reason of any provision of law or any government program or regulation;
(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. BENEFIT DEDUCTIBLES AND COINSURANCE

Cash Deductible: Each Benefit Period, You must have Covered Charges that exceed the Deductible before We pay any benefits to You for those charges. The Deductibles are shown in the {schedule} **Schedule of Benefits section of this Policy.** The Deductibles cannot be met with Non-Covered Expenses. Only Covered Charges incurred by the You while insured can be used to meet the Deductible for those charges.

Once a Deductible is met, We pay benefits for other Covered Charges above the Deductible amount incurred by You, less any applicable Coinsurance and Copayments, for the rest of that Benefit Period. But all charges must be incurred while You are insured by this Policy. And what We pay is based on all the terms of this Policy including benefit limitations and exclusion provisions.

Family Deductible Cap: This Policy has a family deductible cap on care equal to two Deductibles for each Benefit Period. Once a family meets the equivalent of two individual Deductibles in a Benefit Period, We pay benefits for other Covered Charges incurred by any member of the covered family for that type of care, less any applicable Copayment and Coinsurance, for the rest of that Benefit Period. What We pay is based on all the terms of this Policy, including benefit limitation and exclusion provisions.

Coinsurance Cap: This Policy limits the Coinsurance amounts You must pay each Benefit Period. The Coinsurance cap cannot be met with Non-Covered Expenses{, Copayments and Deductibles} **and Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse.**

There is a Coinsurance cap for each Covered Person. The Coinsurance cap is shown in the "Schedule of Benefits."

Each Covered Person's Coinsurance amounts are used to meet his /**her** own Coinsurance cap. And all amounts used to meet the cap must actually be paid by You.

Once Your Coinsurance amounts in a Benefit Period exceed the individual cap, We waive Your Coinsurance for the rest of that Benefit Period.

THERE WILL BE NO CARRYOVER OF DEDUCTIBLES OR COINSURANCE INTO THE NEXT BENEFIT PERIOD.

Deductible Credit: **For the first Benefit Period of this Policy, a Covered Person will receive credit for any Deductible amounts satisfied under previous coverage within the same calendar year that Your first Benefit Period starts under this Policy.**

This credit will be applied whether Your previous coverage was under a plan with Us or with another carrier. You will be required to provide Us with adequate documentation of the amounts satisfied.

Payment Limits: We limit what We pay for certain types of charges.

{Benefits From Other Plans: When another plan furnishes benefits which are similar to Ours, We coordinate our benefits with the benefits from that other plan. However, You are not eligible for coverage under this Policy if You are eligible for benefits under a Group Health Benefits Plan that provides the same or similar coverage. We do this so that no one gets more in benefits than he incurs in charges. Read the section of this Policy called "Coordination of Benefits" to see how this works.}

VI. COVERED CHARGES

We will pay benefits if, due to an Accidental Injury or Illness, You incur Medically Necessary and Appropriate Covered Charges during a Benefit Period. Unless stated, all benefits are subject to Copayment, Deductibles, Coinsurance, other limits and exclusions shown in the Schedule of Benefits, along with other provisions in this Policy.

OUR PAYMENT WILL BE REDUCED IF YOU DO NOT COMPLY WITH THE UTILIZATION REVIEW SECTION OF THIS POLICY.

This section lists the types of charges We cover. But what We pay is subject to all the terms of this Policy. Read the entire Policy to find out what We limit or exclude.

Alcoholism: We pay benefits for the treatment of alcohol abuse the same way We would for any other Illness, if such treatment is prescribed by a {Doctor} **Practitioner.** But We do not pay for Custodial Care, education, or training.

Treatment may be furnished by a Hospital or Substance Abuse Center. But Outpatient treatment must be carried out under an approved alcohol abuse program.

Ambulance: We will cover medical transportation to an eligible {facility} **Facility,** for a Medical Emergency. For non-Medical Emergency situations, medical transportation will be covered only with prior written approval.

Anesthesia Services: We cover the charges incurred for the administration of anesthesia by a {Doctor} **Practitioner** other than the surgeon or assistant at Surgery.

Benefits for a Covered Newborn Dependent: We cover the care and treatment of a covered newborn if the child is Ill, Accidentally Injured, premature, or born with a congenital birth defect.

And We cover charges for the Child's Routine Nursery Care while the Child is in the Hospital. This includes: (a) nursery charges; (b) charges for routine {Doctor} **Practitioner's** examinations and tests; and (c) charges for routine procedures, like circumcision.

Birthing Center Charges: We cover Birthing Center charges made for prenatal care, delivery, and postpartum care in connection with Your pregnancy. We cover Reasonable and Customary charges and Routine Nursing Care shown in the Schedule of Benefits when Inpatient care is provided to You by a Birthing Center.

We cover all other services and supplies during the confinement. But, We do not cover routine nursery charges for the newborn Child unless the child is a Dependent.

Blood: We cover blood, blood products and blood transfusions, except as limited in the section of this Policy called "Exclusions."

Daily room and board limits{:}

During a Period of Hospital Confinement:

For semi-private room and board accommodations, We cover charges up to the Hospital's actual daily room and board charge.

For private room and board accommodations, We cover charges up to the Hospital's average daily semi-private room and board charge or, if the Hospital does not have semi-private accommodations, {90%} **80%** of its lowest daily room and board charge.

For Special Care Units, We cover charges up to the Hospital's actual daily room and board charge.

Dialysis Center Charges: We cover charges made by a dialysis center for covered dialysis Therapy Services.

{Doctor} **Practitioner** Charges for Nonsurgical Care and Treatment: We cover {Doctor} **Practitioner** charges for nonsurgical care and treatment of an Illness or Accidental Injury. See the "Schedule of Benefits" section of this Policy.

{Doctor} **Practitioner** Charges for Surgery: We cover {Doctor} **Practitioner** charges for Surgery. But, We do not cover cosmetic Surgery.

Durable Medical Equipment: Subject to Our advance written approval, We cover charges for the rental of Durable Medical Equipment needed for therapeutic use. In Our Discretion, and with Our advance written approval, We may cover the purchase of such items when it is less costly and more practical than renting. But We do not pay for: (a) any purchases without Our advance written approval; (b) replacements or repairs; or (c) the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not meet the definition of Durable Medical Equipment.

Home Health Care Charges: Subject to Our advance written approval, when home health care can take the place of Inpatient care, We cover such care furnished to You under a written home health care plan. We cover all services or supplies, such as:

(a) Skilled Nursing Care [furnished by or under the supervision of a registered Nurse];
(b) Therapy Services;
(c) medical social work;
(d) nutrition services;

(e) home health aide services;
(f) medical appliances and equipment, drugs and medications, laboratory services and special meals{.} ; **and**
(g) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
1. Your Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
2. The services and supplies must be:
—ordered by Your Practitioner;
—included in the home health care plan; and
—furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

But payment is subject to all of the terms of this Policy and to the following conditions:

(a) Your {Doctor} **Practitioner** must certify that home health care is needed in place of Inpatient care in a recognized {facility} **Facility.**
(b) The services and supplies must be: (a) ordered by Your {Doctor} **Practitioner;** (b) included in the home health care plan; and (c) furnished by, or coordinated by, a Home Health Agency according to the written home health care plan. The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24-hour service is needed on a short-term basis.
(c) The home health care plan must be set up in writing by Your {Doctor} **Practitioner** within 14 days after home health care starts. And it must be reviewed by Your {Doctor} **Practitioner** at least once every 60 days.
(d) Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

We do not pay for: (a) services furnished to family members, other than the patient; or (b) services and supplies not included in the home health care plan.

Hospice Care Charges: Subject to Our advance written approval, We cover charges made by a Hospice for palliative and supportive care furnished to You if You are terminally Ill under a Hospice care program {, up to 180 days per Benefit Period}. **Additionally, We Cover Charges for counseling provided to any family members who are also Covered Persons when that counseling is for the sole purpose of adjusting to the terminally Ill Covered Person's death.**

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure Your terminal Illness.

"Terminally Ill" means that Your {Doctor} **Practitioner** has certified in writing that Your life expectancy is six months or less.

Hospice care must be furnished according to a written hospice care program. A "hospice care program" is a coordinated program for meeting Your special needs If You are terminally Ill. It must be set up in writing and reviewed periodically by Your {Doctor} **Practitioner.**

Under a Hospice care program, subject to all the terms of this Policy, We cover any services and supplies to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
(a) needed for palliative and supportive care;
(b) ordered by Your {Doctor} **Practitioner;**
(c) included in the Hospice care program; and
(d) furnished or coordinated by a Hospice.

We do not pay for:
(a) services and supplies provided by volunteers or others who do not regularly charge for their services;
(b) funeral services and arrangements;
(c) legal or financial counseling or services;
(d) treatment not included in the Hospice care plan; **or**
(e) services supplied to family members **who are not Covered Persons.** {other than the terminally Ill Covered Person; or
(f) counseling of any type which is for the sole purpose of adjusting to the terminally Ill Covered Person's death.}

. . .

{**Outpatient Hospital Services:** We cover Outpatient Hospital services and supplies provided in connection with the treatment of Accidental Injury, but only if the treatment is given within 72 hours of an Accident. All services are covered only if You comply with the "Utilization Review" section of this policy. We cover Hospital Admission Review and Pre-admission Testing, Surgery, Dialysis Treatment, Radiation Therapy and Chemotherapy.}

Outpatient Hospital Services: **We cover Outpatient Hospital services and supplies provided in connection with covered Admission Review and Preadmission Testing, Surgery, Therapy and Accidental Injury (but only if the treatment is given within 72 hours of an Accident). All services are covered only if You comply with the Utilization Review section of this policy.**

. . .

Second Opinion Charges: We cover {Doctor} **Practitioner** charges for a second opinion and charges for related x-rays and tests when You are advised to have Surgery or enter a Hospital. If the second opinion differs from the first, We cover charges for a third opinion. If you fail to obtain a second opinion when {we} **We** require one, Your benefits will be reduced. See the section of this Policy called "Utilization Review" for details.

Skilled Nursing Care: Subject to Our advance written approval, We cover charges made by a Skilled Nursing Center up to 120 days per Benefit Period, including any diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a office or any other licensed health care {facility} **Facility,** provided such service is administered in a Skilled Nursing Center.

{**Treatment for Therapeutic Manipulation:** We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.}

Treatment of Wilm's Tumor: **We pay Covered Charges incurred for the treatment of Wilm's tumor. We treat such charges the same way We treat Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. We cover this treatment even if it is deemed Experimental or Investigational. Benefit amounts are based on all of the terms of this Policy.**

X-Rays and Laboratory Tests: We cover x-rays and laboratory tests to treat an Illness or Accidental Injury. But, except as covered under the "Primary Care Services" section of this Policy, We do not pay for x-rays and tests done as part of routine physical checkups.

VII. CHARGES COVERED WITH SPECIAL LIMITATIONS

***Dental Care and Treatment*—We cover:**
(a) the diagnosis and treatment of oral tumors and cysts; and
(b) the surgical removal of bony impacted teeth.

We also cover treatment of an Accidental Injury to natural teeth or the jaw, but only if:
(a) the Injury occurs while You are insured under any health benefit plan;
(b) the Injury was not caused, directly or indirectly by biting or chewing; and
(c) all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Accidental Injury. But in no event do We cover orthodontic treatment.

Mental or Nervous Conditions and Substance Abuse: We limit what We pay for the treatment of Mental or Nervous Conditions and Substance Abuse. We include an Illness under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

You may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. However, this Policy contains penalties for noncompliance with Our preapproval requirements. See the section of this Policy called "Utilization Review" for details. You may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or [any properly licensed or certified {Doctor} **Practitioner,** psychologist or social worker].

You must pay Coinsurance of 25% for Covered Charges for Inpatient and Outpatient treatment. We limit what We pay to $5,000 for combined

Inpatient and Outpatient treatment per Covered Person per Benefit Period. We will pay a Per Lifetime maximum of $25,000 combined Inpatient and Outpatient benefit.

Routine Practitioner's office visits that involve monitoring a Covered Person's care when the Covered Person is involved in an ongoing maintenance treatment program for a Mental or Nervous Condition and any associated Prescription Drugs are covered the same as Covered Charges for any other Accidental Injury or Illness. These Covered Charges are not subject to and do not count towards the limitations defined above.

We do not pay for Custodial Care, education, or training.

Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until You have been covered by this Policy for twelve months. See the "Definitions" section of this Policy for the definition of a Pre-Existing Condition.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent Child **or complications of pregnancy as defined in N.J.A.C. 11:1-4.3**. We waive this limitation for Your Pre-Existing Condition if, under a prior group or individual health benefits plan **delivered or issued for delivery in the United States**, with no intervening lapse in coverage, You have been treated or diagnosed by a physician for a condition under that plan or satisfied a 12 month preexisting condition limitation **for a condition covered by that plan.**

Primary Care Services: We will cover up to $300 per Covered Person. For Newborns, We pay $500 in Covered Charges for the first year of life. The following are included: routine physical examinations, diagnostic Services, vaccinations, inoculations, x-ray, mammography, pap smear, and screening tests related to Primary Care Services. However, no benefits are available beyond the maximums stated above.

These charges are not subject to the Cash Deductibles or Coinsurance.

Private Duty Nursing Care: **We *only* cover charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the *Home Health Care Charges* section. Any other charges for private duty nursing care are a Non-Covered Charge.**

Prosthetic Devices: We limit what We pay for prosthetic devices. Subject to prior written approval, We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of Your body, or be needed due to a functional birth defect in a covered Dependent Child. We do not pay for replacements, **unless they are Medically Necessary and Appropriate, We do not pay for** repairs, wigs, or dental prosthetics or devices.

Therapy Services: We cover the Therapy Services listed in the "Definitions" section of this Policy. However, We only cover 30 visits per Benefit Period for {most} Therapy Services **other than Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy.**

We cover Radiation Therapy, {and} Chemotherapy **Chelation, Dialysis and Respiration Therapy** as We would any other Illness, without the visit limitation.

We cover Infusion Therapy subject to Our prior written approval.

Treatment for Temporomandibular Joint Disorder (TMJ): **We cover surgical and non-surgical treatment of TMJ in a Covered Person. However, We do not cover any charges for orthodontia, crowns or bridgework.**

Treatment for Therapeutic Manipulation: **We limit what We cover for Therapeutic Manipulation to 30 visits per Benefit Period. Charges for such treatment above these limits are Non-Covered Expenses.**

Transplants: {Subject to Our prior written approval, We cover Inpatient Hospital services and supplies provided in connection with bone marrow transplants for leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders.

The following organ transplants are also covered subject to prior written approval: cornea, heart valves, kidney, heart and heart-lung, liver, single lung, pancreas.}

We cover Medically Necessary and Appropriate services and supplies for the following types of transplants:

(a) Cornea
(b) Kidney
(c) Lung
(d) Liver
(e) Heart
(f) Heart-Lung
(g) Heart Valves
(h) Pancreas
(i) Allogeneic Bone Marrow
(j) Autologous Bone Marrow and Associated High Dose Chemotherapy *only* for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  - SCID
  - WISCOT Alldrich
- Subject to Our prior written approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by Us in writing are Non-Covered Charges.**

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.

VIII. UTILIZATION REVIEW

OUR PAYMENT WILL BE REDUCED AS INDICATED BELOW FOR NONCOMPLIANCE WITH THE PROVISIONS SET FORTH IN THIS SECTION. YOU WILL BE RESPONSIBLE FOR PAYING TO THE PROVIDER THE AMOUNT OF THE REDUCTION (IN ADDITION TO ANY OTHER PAYMENTS YOU ARE REQUIRED TO MAKE UNDER THIS POLICY).

We are not responsible for medical or other results arising directly or indirectly from Your participation or lack of participation in this Utilization Review program.

STEP 1—Request {Our} *For* Care Preapproval

If Your Provider recommends that You (a) be admitted, for any reason, as an Inpatient (except for a normal vaginal delivery); or (b) undergo any of the Surgical procedures or other services or supplies listed below, You must first obtain Our authorization to Determine whether We agree that the Surgery or other services and supplies are Medically Necessary and Appropriate.

SURGICAL PROCEDURES

Adenoidectomy
Arthroscopy
Bunionectomy
Carpal Tunnel Surgery
Cesarean Section
Cholecystectomy
Coronary Artery Angioplasty
Coronary Artery Bypass Graft
Esophagoscopy
Excision of Intervertebral Disk
Gastroduodenoscopy
Hip Replacement
Human Organ/Bone Marrow Transplants
Hysterectomy
Knee Replacement
Lower Back Surgery
Mastectomy
Meniscectomy
Myringotomy
Pacemaker Implantation
Prostatectomy
Rhinoplasty
Septectomy with Rhinoplasty
Tonsillectomy
Transplants
Tubal Transection and/or Ligation
Tympanoplasty
{Tympanostomy} **Tympanotomy** Tube

MEDICAL PROCEDURES

Lower Back Medical Care
{CAT Scan}
{Magnetic Resonance Imaging}

DIAGNOSTIC PROCEDURES

Cardiac Catheterization
CAT Scan
Cystoscopy
Magnetic Resonance Imaging

OTHER SERVICES AND SUPPLIES

Ambulance for Non-Medical Emergency
Home Health Care
Hospice Care
Skilled Nursing Care
Durable Medical Equipment
Private Duty Nursing
Prosthetics
Infusion Therapy

To obtain Our authorization, You or Your Provider must request Our review. **In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 3" below.**

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL REDUCE ANY PAYMENT WE MAKE BY 50%. ANY REDUCTION OF BENEFITS UNDER THIS PROVISION ARE SUBJECT TO YOUR RIGHTS UNDER THE CLAIMS APPEAL SECTION OF THE CLAIMS PROCEDURE PROVISION OF THIS POLICY.

{NOTE: For ***Non-Medical Emergency*** procedures, services and supplies listed above, You or Your Provider must ***contact Us at least 3 days prior to treatment*** or purchase. For ***Medical Emergency procedures, services and supplies*** You or Your Provider must contact Us ***within 48 hours or on the next business day,*** from treatment whichever is later.

In some instances, before We authorize the procedures, services and supplies listed above, We may require a second opinion. See "Step 2" below.

IF YOU DO NOT REQUEST OUR AUTHORIZATION, OR IF WE DO NOT AUTHORIZE THE PROCEDURES, SERVICES AND SUPPLIES WE WILL MAKE NO PAYMENT AND CHARGES FOR THOSE PROCEDURES, SERVICES AND SUPPLIES WILL BE NON-COVERED EXPENSES.}

STEP 2—Notice Requirements

For *Non-Medical Emergency* procedures, services and supplies listed above, You or Your Provider must *contact Us at least 3 days prior to treatment* or purchase.

For *Medical Emergency procedures, services and supplies* You or Your Provider must contact Us *within 48 hours or on the next business day,* from treatment whichever is later.

[For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us within 24 hours prior to preapproved discharge date for additional authorization.]

If We are notified within the required time and We Determine that the procedures, services and supplies are Medically Necessary and Appropriate, Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE ARE NOT NOTIFIED WITHIN THE TIME SPECIFIED, WE WILL {MAKE NO PAYMENT} *REDUCE ANY PAYMENT BY 50%.***

Failure to notify Us of the procedures, services or supplies listed above will not affect Our payment if We Determine that notice was given to Us as soon as was reasonably possible.

STEP {2} *3*—Obtain a Second Opinion

If We Determine that a second opinion is not necessary for the proposed procedure, then You should proceed with Step {3} **4** below.

If We Determine that a second opinion is necessary, We will arrange for a second opinion consultation prior to Your undergoing the medical, diagnostic or surgical procedure or being admitted as an Inpatient. We will pay for this consultation and for any Diagnostic Services and Pre-Admission Testing necessary for the second opinion, subject to all Policy limitations and exclusions.

If the second opinion confirms the need for the procedure, then You should proceed with Step {3} **4** below.

If the second opinion does not confirm the need for the procedure, We may require {you} **You** to get a third opinion. If that happens, We will arrange and pay for the third opinion. If the third opinion confirms the need for the procedure, You should then proceed with Step {3} **4** below.

NOTE: We will only pay for a second or third surgical opinion which We authorize and arrange.

IF THE SECOND AND THIRD OPINION DO NOT CONFIRM THE NEED FOR THE PROCEDURE, AND YOU PROCEED WITH THE PROCEDURE, **WE WILL NOT PAY FOR THE PROCEDURE NOR ANY** ASSOCIATED **PROVIDER** (INCLUDING FACILITY) **CHARGES.** IF YOU DO NOT OBTAIN A SECOND AND/OR THIRD OPINION WHICH WE HAVE ASKED YOU TO OBTAIN, **OUR PAYMENT** FOR THE PROCEDURE **WILL BE REDUCED BY 20%** PROVIDED WE DETERMINE THE PERFORMANCE OF THE PROCEDURE WAS MEDICALLY NECESSARY AND APPROPRIATE; IF WE DETERMINE THAT PERFORMANCE OF THE PROCEDURE WAS NOT MEDICALLY APPROPRIATE, **WE WILL NOT MAKE ANY PAYMENT.**

A confirming second or third opinion is valid for 90 days. If You do not undergo the procedure within that time, You must call Us and renew the confirming opinion prior to the procedure being performed. If the confirming opinion is not renewed, We may consider the confirming opinion not authorized.

STEP {3} *4*—Obtain Hospital Admission Review

If You called for Our authorization and (a) We Determined that a second opinion was not necessary; or (b) You followed the second opinion process outlined in Step [2] 3 above and the second opinion has confirmed the need for the procedure, We will then Determine what setting (Inpatient or Outpatient) is appropriate for the proposed procedure. If We approve an Inpatient admission, You may proceed with the admission and Our Payment will not be affected—We will pay up to the limits of this Policy. **IF WE DO NOT AUTHORIZE AN INPATIENT ADMISSION AND YOU PROCEED WITH THAT ADMISSION, {WE WILL NOT MAKE} ANY PAYMENT FOR FACILITY CHARGES *WILL BE REDUCED BY 50%.***

Our approval is valid for 30 days. If the admission does not occur as planned, You or Your Provider must contact Us to renew the approval. If the approval is not renewed, We will consider the Inpatient admission not authorized.

[IX. ALTERNATE TREATMENT

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by Us.

Definitions

***"ALTERNATE TREATMENT"* means those services and supplies which meet both of the following tests:**

- **a. They are determined, in advance, by Us to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.**
- **b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.**

***"CATASTROPHIC ILLNESS OR INJURY"* means one of the following:**

- **a. head injury requiring an Inpatient stay**
- **b. spinal cord Injury**
- **c. severe burn over 20% or more of the body**
- **d. multiple injuries due to an accident**
- **e. premature birth**
- **f. CVA or stroke**
- **g. congenital defect which severely impairs a bodily function**
- **h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure**
- **i. terminal Illness, with a prognosis of death within 6 months**
- **j. Acquired Immune Deficiency Syndrome (AIDS)**
- **k. chemical dependency**
- **l. mental, nervous and psychoneurotic disorders**
- **m. any other Illness or Injury determined by Us to be catastrophic.**

Alternate Treatment Plan

We will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, We will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by We through discussion and agreement with:

- **a. the Covered Person, or his or her legal guardian, if necessary;**

b. the Covered Person's attending Practitioner; and
c. Us.

The Alternate Treatment Plan includes:
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- **Us**
- **attending Practitioner**
- **Covered Person**
- **Covered Person's family, if any; and**

d. estimated cost and savings.

If We, the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon Alternate Treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusions

Alternate Treatment does not include services and supplies that We determines to be Experimental or Investigational.]

[X. CENTERS OF EXCELLENCE

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with Us to provide health benefit services for specific procedures. [The Centers of Excellence are identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:
a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

IX. *[XI.]* EXCLUSIONS

THE FOLLOWING ARE *NOT COVERED CHARGES UNDER THIS POLICY. WE WILL NOT PAY FOR ANY CHARGES INCURRED FOR, OR IN CONNECTION WITH:*

Acupuncture, except for use as an anesthesia when the usual method of anesthesia is not medically appropriate.

Ambulance, in the case of a non-Medical Emergency, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Dental care or treatment{,} (including appliances) **except as otherwise specifically Covered.**

...

Facility charges (e.g., operating room, recovery room, use of equipment) when billed for by a Provider that is not an eligible {facility} **Facility**

.

{Fluoroscopy or x-ray examinations without film.}

...

Local anesthesia charges billed separately by a {Doctor} **Practitioner** for surgery **he or she** performed on an Outpatient basis.

...

Private-Duty Nursing, unless You have followed the section of this Policy called "Request {Our} **For** Care Preapproval."

...

Routine Foot Care, **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:
- —eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;
- —for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;
- —for which You would not have been charged if You did not have health care coverage;
- —for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;
- —for which the Provider has not received a certificate of need or such other approvals as are required by law;
- —furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;
- —in an amount greater than a Reasonable and Customary charge;
- —needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony;
- —provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.
- —provided by or in any locale outside the United States, except in the case of a Medical Emergency;
- —provided by a licensed pastoral counselor in the course of the counselor's normal duties as a pastor or minister;
- —provided by a social worker, except as otherwise stated in this Policy;
- —received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;
- —rendered prior to Your Effective Date of coverage or after {your} **Your** termination date of coverage under this Policy;
- —which are specifically limited or excluded elsewhere in this Policy;
- —which are not Medically Necessary and Appropriate; or
- —which You are not legally obligated to pay.

...

{TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.}

Transplants, except as described in the section of this Policy called "Covered Charges" under "Transplants."

Transportation; travel.

{Vision therapy, vision or visual acuity training, orthoptics and pleoptics.}

...

X. *[XII.]* CLAIMS PROCEDURES

...

Claims Appeal: If We decline Your claim in whole or in part, We will {let You know} **send You an explanation of benefits** in writing. Within 60 days after receiving Our written notice of declination, You may request that We reconsider any portion of the claim for which You believe benefits were wrongly declined. Your request for reconsideration must be in writing, and include:
(a) name(s) and address(es) of patient and Policyholder;
(b) Policyholder's [identification] number;
(c) date of service;
(d) claim number;

(e) Provider's name; and
(f) why the claim should be reconsidered.

You may, within 45 days of Our receipt of Your request for reconsideration, review pertinent documents at Our office during regular business hours. We may require written releases if We Determine the information to be sensitive or confidential.

You may also, within 45 days of Our receipt of Your request for reconsideration, submit to Us issues and comments and any additional pertinent medical information.

We will give You a written decision within 60 days after We receive Your request for review. That written decision will indicate the reasons for the decision and refer to the Policy provision(s) on which it was based.

In special circumstances, We may Determine that additional time is necessary to make a decision. We will let You know if this happens but it will never be more than 120 days from the date {of the original declination} **after We receive Your request for review.**

Limitations of Actions: You cannot bring a legal action against this Policy until 60 days from the date You file proof of loss. And You cannot bring legal action against this Policy after three years from the date You file proof of loss.

XI. *[XIII.]* {COORDINATION OF BENEFITS} *BENEFITS FROM OTHER PLANS*

{This provision applies to all Covered Charges under this Policy. It does not apply to death, dismemberment, or loss of income benefits.

If You incur Covered Charges under this Policy and these same expenses are covered under Other Valid Coverage, Our Payment will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our Payment on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under Other Valid Coverage of which We had notice;
(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Charges) under all Other Valid Coverage (whether or not We had notice);
(c) divide the total in (1) by the total in (2) to calculate a percentage; and
(d) multiply the percentage calculated in step (3) by the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information form any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action.

When payment that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver: We do not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more Covered Charges are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.}

This provision applies to all Covered Charges under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You incur Claims under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount. To the extent You have not paid the full premium amount, We will offset the amount due from any benefit amount payable for Covered Charges.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

***Our Right To Certain Information:* In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.**

[XII. [XIV.] RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no- fault tort liability of a third party.]

XII. *[XIV.] [XV.]* GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

(a) the forms shown in the Table of Contents as of the Effective Date;
(b) the Policyholder's application, a copy of which is attached to the Policy;
(c) any riders, endorsements or amendments to the Policy; and
(d) the individual applications, if any, of all Covered Persons.

STATEMENTS

No statement will {avoid} **void** the insurance, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

...

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

Premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your} **Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's Eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

OTHER RIGHTS

This Policy is intended to pay benefits for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide benefits to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Policy.

We reserve the right to modify or replace an erroneously issued Policy.

We reserve the right to reasonably require that You be examined by a {Doctor} **Practitioner** of Our choice and at Our expense while Your claim is pending.

We reserve the right to obtain, at Our expense, an autopsy to determine the cause of Your death if that would affect Your claim for benefits.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.

...

{OTHER PROVISIONS

This Policy is intended to pay for Covered Charges in cash or in kind. It is not intended to provide services or supplies themselves, which may, or may not, be available.

We are only required to provide Payment to the extent stated in this Policy, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate other companies or carrier's employees in administering this Policy.

We reserve the right to modify or replace an erroneously issued policy.

Information in Your application may not be used by Us to void this Policy or in any legal action unless the application or a duplicate of it is attached to this Policy or has been furnished to You for attachment to this Policy.}

PAYMENT AND CONDITIONS OF PAYMENT

For eligible services from an eligible {facility} **Facility** or {Doctor} **Practitioner**, We will Determine to pay either You or the {facility} **Facility** or {Doctor} **Practitioner.**

Payment for all other Covered Charges will be made directly to You unless, before submission of each claim, You request in writing that Payment be made directly to the Provider and We agree to do this.

Except as provided above, in the event of Your death or total incapacity, any Payment or refund due will be made to Your heirs, beneficiaries, or trustees.

If We make Payments to anyone who is not entitled to them under this Policy, We have the right to recover these Payments from that individual or entity or You.

...

APPENDIX

EXHIBIT F

This Policy has been approved by the New Jersey Individual Health Coverage Program Board as the standard policy form for the HMO health benefits plan.

...

Renewal Provision. Subject to all Policy terms and provisions, including those describing Termination of the Policy, You may renew and keep this Policy in force by paying the Premiums as they become due. We agree to arrange or provide services under the terms and provisions of this Policy. {But, Your coverage (and that of Your Dependents) may be ended earlier as stated in the Policy.}

Premiums. We may only change the Premiums for this Policy if We change the Premiums for a reason permitted under the "Premium Rates and Provisions" section, or for everyone whom We cover under this HMO Health Benefits Plan.

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I. DEFINITIONS

The words shown below have specific meanings when used in this Policy. Please read these definitions carefully. Throughout the Policy, these defined terms appear with their initial letters capitalized. They will help You to understand what services are provided. Information about the services provided under this Policy begins on page {-}**22.**

...

[ASSOCIATED MEDICAL GROUPS. **Any Medical Group with which we contract directly to provide Covered Services to Members including the [ ]].**

BENEFIT PERIOD. The twelve-month period starting on January 1st and ending on December 31st. Your first and/or last Benefit Period may be less than a Calendar Year. Your first Benefit Period begins on Your Effective Date. Your last Benefit Period ends when You are no longer {insured} **covered** by this Policy.

BIRTHING CENTER. A {facility} **Facility** which mainly provides care and treatment for people during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

(a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
(b) be staffed and equipped to give Medical Emergency care; and
(c) have written back-up arrangements with a local Hospital for Medical Emergency care.

It must also:

(a) carry out its stated purpose under all relevant state and local laws; or
(b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
(c) be approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Birthing Center if it is part of a Hospital.

BOARD. The New Jersey Individual Health Coverage Program Board, appointed and elected under the laws of New Jersey.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

CHILD. Your own issue or {your} **Your** legally adopted child and, if the child depends on You for most of its support and maintenance, Your step-child. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Also, any child over whom {you} **You** have legal custody or legal guardianship is considered a Child under this Policy. (We may require that {you} **You** submit proof of legal custody or legal guardianship, in Our Discretion.)

However, a foster child or grandchild of the Policyholder or the Policyholder's Spouse is not a Child for purposes of eligibility for services under this Policy.

...

DEPENDENT.

(a) Your:
  (1) Spouse;
  (2) unmarried Child who is under age {20} **19**;
  (3) unmarried Child from age {20} **19** until the Child's 23rd birthday, who is enrolled as a full-time student at an accredited school (We can ask You to provide periodic proof that the Child is so enrolled); and
  (4) unmarried Child for whom You are obligated by a court order to provide health benefit plan coverage.

(b) Your unmarried Child who has a mental or physical handicap, or developmental disability, remains a Dependent beyond this Policy's age limit, if:
  (1) the Child remains unmarried and unable to support {itself} **himself or herself**;
  (2) the Child's condition started before the Child reached this Policy's age limit;
  (3) the Child became insured before the Child reached this Policy's age limit, and stayed continuously insured until the Child reached such limit; and
  (4) the Child depends on You for most of its support and maintenance.

  In order for the Child to remain a Dependent, You must send Us written proof that the Child is handicapped and depends on You for most of its support and maintenance. You have 31 days from the date the Child reaches this Policy's age limit to do this. We can ask for periodic proof that the Child's condition continues. After two years, We cannot ask for this proof more than once a year.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who resides in a foreign country. **However, this does not apply to a person who is attending an accredited school in a foreign country who is enrolled as a student for up to one year at a time.**

...

{DOCTOR. A medical practitioner We are required by law to recognize who:

(a) is properly licensed or certified to provide medical care under the laws of the state where practicing; and
(b) provides medical services which are within the scope of the license or certificate and which are covered by this Policy.}

...

EFFECTIVE DATE. The date on which coverage begins under this Policy for You or {your} **Your** Dependents, as the context in which the term is used suggests.

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies, including treatments, procedures, hospitalizations, drugs, biological products or medical devices, which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of Your particular condition; or
(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of Your particular condition; or
(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of Your particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of Your particular condition **as explained below**.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

{1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemp-

tion or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;}

1. **any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:**
   —The American Medical Association Drug Evaluations;
   —The American Hospital Formulary Service Drug Information; or
   —The United States Pharmacopeia Drug Information.
   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.
   In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FACILITY. **A place We are required by law to recognize which:**

(a) is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

(b) provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

...

[*HEALTH CENTER (or HEALTH CARE CENTER)*—Any place operated by or on behalf of an HMO where [Network] [Participating] Provides Covered Services and Supplies to Members]

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Accidentally Injured people in their home under a home health care program designed to eliminate Hospital stays. We will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare das a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Accidentally Injured people who are terminally injured. It carries out it stated purpose under all relevant state and local laws, and it is {either}:

(a) approved for its stated purpose by Medicare; {or}

(b) accredited for its stated purpose by the Joint Commission{.}; **or**

(c) accredited or licensed by the state of New Jersey.

HOSPITAL. A {facility} **Facility** which mainly provides Inpatient care for Ill or Accidentally Injured people. It carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited as a hospital by the Joint Commission, {o}

(b) approved as a Hospital by Medicare{.}**or**

(c) accredited or licensed by the state of New Jersey.

Among other things, a Hospital is not a convalescent, rest or nursing home or {facility} **Facility**, or a {facility} **Facility**, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care.

A {facility} **Facility** for the aged or for Substance Abusers or Alcoholics is not a Hospital.

A specialty {facility} **Facility** is also not a Hospital.

ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.

INPATIENT. You, if You are physically confined as a registered bed patient in a Hospital or other recognized health care {facility} **Facility**; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

[*MAINTENANCE DRUG.* A Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes(oral agents only); glaucoma; hypertension; thyroid disease; seizure disorders.]

...

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease or Accidental Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury;

(c) in accordance with accepted medical standards in the community at the time;

(d) not for Your convenience; and

(e) the most appropriate level of medical care that You need.

The fact that an attending {Doctor} **Practitioner** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

...

MENTAL HEALTH CENTER. A {facility} **Facility** that {mainly} provides treatment for people with mental health problems. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}

(b) approved for its stated purpose by Medicare{.}; **or**

(c) accredited or licensed by the state of New Jersey.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental {and} **or** Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement with Us **[or Our Associated Medical Groups]** to provide Covered Services or Supplies.

...

OUTPATIENT. You, if You are registered at a recognized health care {facility} **Facility** and not an Inpatient; or services and supplies provided in such a setting.

PRACTITIONER. **A person [Carrier] is required by law to recognize who:**

(a) is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

(b) provides medical services which are within the scope of his or her license or certificate and which are covered by this Policy.

PARTIAL HOSPITALIZATION. Day treatment services for Mental {and }**or** Nervous Conditions consisting of intensive short-term non-residential psychiatric and/or substance abuse treatment rendered for any part of a day for a minimum of four consecutive hours per day (must be in lieu of an Inpatient stay).

PER LIFETIME. Your lifetime, regardless of whether You are covered under this Policy:

(a) as a Dependent or Policyholder; and

(b) with or without interruption of coverage.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized {facility} **Facility** occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PHARMACY. A {facility} **Facility** which is registered as a Pharmacy with the appropriate state licensing agency and in which Prescription Drugs are regularly compounded and dispensed by a Pharmacist.

...

PRE-EXISTING CONDITION. An Illness or Accidental Injury which manifests itself in the six months before Your coverage under this Policy starts, and for which:

(a) You see a {Doctor} **Practitioner**, take prescribed drugs, receive other medical care or treatment or had medical care or treatment recommended by a {Doctor} **Practitioner** in the six months before Your coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his coverage starts.

A pregnancy which exists on the date Your coverage starts is also a Pre-Existing Condition. **However, complications of such a pregnancy as defined by N.J.A.C. 11:1-4.3 are not considered to be Pre-Existing Conditions and are not subject to Pre-Existing Condition Limitations. See the exclusions section of this Policy for details on how this Policy limits the services for Pre-Existing Conditions.**

...

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a {Doctor} **Practitioner** specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for OB/GYN services only),] or pediatrics who supervises, coordinates and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIMARY RESIDENCE. The location where You reside for a majority of the Calendar Year with the intention of making Your home there and not for a temporary purpose. Temporary absences from New Jersey, with the intent to return, will not interrupt Your Primary Residence in New Jersey.

PROVIDER. A recognized {facility} **Facility** or {practitioner} **Practitioner** of health care.

REFERRAL. Specific direction or instruction from Your Primary Care Physician [or Care Manager] or that directs You to a {facility} **Facility** or Provider for health care.

REHABILITATION CENTER. A {facility} **Facility** which mainly provides therapeutic and restorative services to Ill or Accidentally Injured people. It carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, {deratomas} **dermatomas**, keratosis, onychauxis, onychocryptosis{,} **or** tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

ROUTINE NURSING CARE. The nursing care customarily furnished by a recognized {facility} **Facility** for the benefit of its Inpatients.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A {facility} **Facility** which mainly provides full-time Skilled Nursing Care for Ill or Accidently Injured people who do not need to be in a Hospital. It carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission; or

(b) approved for its stated purpose by Medicare.

SPECIAL CARE UNIT. A part of a Hospital set up for very Ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of special care units are: (a) intensive care units; (b) cardiac care units; (c) neonatal care units; and (d) burn units.

SPECIALIST {DOCTOR} ***PRACTITIONER.*** A {Doctor} **Practitioner** who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

...

SUBSTANCE ABUSE CENTERS. A {facility} **Facility** that mainly provides treatment for Substance Abuse. We will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is {either}:

(a) accredited for its stated purpose by the Joint Commission; {or}

(b) approved for its stated purpose by Medicare{.} **or**

(c) accredited or licensed by the state of New Jersey.

...

SURGICAL CENTER. A {facility} **Facility** mainly engaged in performing Outpatient Surgery. It must:

(a) be staffed by {Doctor} **Practitioners** and Nurses, under the supervision of a {Doctor} **Practitioner**;

(b) have permanent operating and recovery rooms;

(c) be staffed and equipped to give emergency care; and

(d) have written, back-up arrangements with a local Hospital for Medical Emergency care.

It carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or

(b) approved for its stated purpose by Medicare.

A {facility} **Facility** is not a Surgical Center if it is part of a Hospital.

...

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from{,} an Accidental Injury or Illness:

...

II. ELIGIBILITY

TYPES OF COVERAGE

A Policyholder who completes an application for coverage may elect one of the types of coverage listed below:

(a) **SINGLE COVERAGE**—coverage under this Policy for the Policyholder only.

(b) **FAMILY COVERAGE**—coverage under this Policy for You and Your Dependent(s).

(c) **PARENT AND CHILD(REN) COVERAGE**—coverage under this Policy for You and all Your Child Dependents **or coverage for multiple children residing within the same residence who share a common legal guardian, or for when there exists a valid support order requiring health benefit coverage whether or not there is an adult who will be provided coverage.**

(d) ***HUSBAND AND WIFE*****—coverage under this Policy for You and Your Spouse.**

WHO IS ELIGIBLE

(a) **THE POLICYHOLDER**—You, if your Primary Residence is in the State of New Jersey and You are not eligible for a Group Health Benefits Plan, Medicare or Medicaid.

(b) **SPOUSE**—Your Spouse who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan.

(c) **CHILD**—Your Child who is not eligible for Medicare, Medicaid or a Group Health Benefits Plan, and who qualifies as a Dependent, as those terms are defined in the "Definition" section of this Policy.

ADDING DEPENDENTS TO THIS POLICY

(a) **SPOUSE**—You may apply {for a Policy to include} **to add** Your Spouse by notifying Us in writing at any time. You must submit an application to Us to change your type of coverage. If your application is made and submitted to Us within 31 days of Your marriage to Your Spouse, the Spouse will be covered from the date of the Spouse's eligibility.

If We do not receive Your written notice within 31 days of Your Spouse becoming eligible, coverage for Your Spouse will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(b) **NEWBORN DEPENDENT**—A Child born to You or Your Spouse while this Policy is in force will be covered for 31 days from the moment of birth. This automatic coverage will be for Covered Services or Supplies incurred as a result of Accidental Injury or Illness, including Medically Necessary and Appropriate care and treatment of medically diagnosed congenital abnormalities.

To continue coverage for such Child for more than 31 days, if You have Single **or Husband and Wife** Coverage, You must apply and pay for Parent and Child(ren) or Family Coverage. If You already have Family or Parent and Child(ren) coverage, the coverage for such Child will be automatically continued.

(c) **CHILD DEPENDENT**—If You have Single **or Husband and Wife** Coverage and want to add a Child Dependent, You must change to Family Coverage or Parent and Child(ren) Coverage. To change coverage, You must submit an application. If Your application is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of the Child's eligibility.

Even if You have Family Coverage or Parent and Child(ren) Coverage, however, You must give Us written notice that You wish to add a Child. If Your written notice to add a Child is made and submitted to Us within 31 days of the Child's becoming a Dependent, the Child will be covered from the date of eligibility.

If We do not receive Your written notice within 31 days of Your Dependent's becoming eligible, coverage for that Dependent will not become effective immediately. Rather, such coverage will become effective on the first day of the month after the date Your application is received.

(d) **YOUR CHILD DEPENDENT'S NEWBORN**—A Child born to Your Child Dependent is not covered under this Policy.

III. SCHEDULE OF SERVICES

BENEFITS FOR COVERED SERVICES OR SUPPLIES UNDER THIS POLICY ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER BENEFIT PERIOD, UNLESS OTHERWISE STATED. BENEFITS ARE PER MEMBER, AND MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

FACILITY BENEFIT—Unlimited days.

COPAYMENTS:

HOSPITAL SERVICES:

INPATIENT—$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Benefit Period.

OUTPATIENT—$15 Copayment/visit

{DOCTOR} *PRACTITIONER* SERVICES:

INPATIENT—None

OUTPATIENT—$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM—$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as the result of the emergency).

. . .

IV. PREMIUM RATES AND PROVISIONS

[The [monthly] premium rates, in U.S. dollars, for the coverage provided under this Policy are:

For Single Coverage	**[$]**
For Parent and Child(ren) Coverage	**[$]**
For Family Coverage	**[$]**
For {Policyholder and Spouse} Husband and Wife	[$]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Policy entitled "Premium Rate Changes."]

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

(a) the amounts of the Premium charges for the Member that was included in the Premiums paid for the two-month period immediately {before} **after** the date the Member's coverage has ended.

(b) the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by You to Us. They are due on each Premium Due Date stated on the first page of the Policy. You may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. You are liable to pay Premiums to Us from the first day the Policy is in force. [Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.]

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Policy. We have the right to change Premium rates as of any of these dates:

(a) any Premium Due Date;

(b) any date that the extent or nature of the risk under the Policy is changed:

(1) by amendment of the Policy; or

(2) by reason of any provision of law or any government program or regulation;

(c) at the discovery of a clerical error or misstatement as described {below} **in the General Provisions section of this Policy.**

We will give You 30 days written notice when a change in the Premium rates is made.

V. COVERED SERVICES *AND SUPPLIES*

You are entitled to receive the benefits in the following sections when Medically Necessary **and Appropriate**, subject to the payment by you of applicable copayments as stated in the applicable Schedule of Benefits.

(a) **Outpatient Benefits.** The following services are covered only at the Primary Care Physician's office **[or Health Center]** selected by {you} **You**, or elsewhere upon prior written referral by Your Primary Care Physician:

. . .

8. **Prosthetic Devices and Durable Medical Equipment** when ordered by {your} **Your** Primary Care Physician and arranged through us. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of {your} **Your** body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements **(unless Medically Necessary and Appropriate)**, repairs, wigs, or dental prosthetics or devices.

9. **Prescription Drugs.**

(b) **SPECIALIST {DOCTOR} *PRACTITIONER* BENEFITS.** The following Services are covered when rendered by a Participating

Specialist {Doctor} **Practitioner** at the {Doctor} **Practitioner's** office**[, or Health Center]** or at a Participating Hospital outpatient department during office or business hours upon prior written referral by your Primary Care Physician. Services include but are not limited to the following:

...

(c) **INPATIENT HOSPITAL, REHABILITATION CENTER AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating {Doctor} **Provider** upon prior written referral from your Primary Care Physician, only at Participating Hospitals and participating Providers (or at non-participating facilities upon prior written authorization by us); however, Participating Skilled Nursing Center benefits are limited to those which are Medically Necessary and which constitute Skilled Nursing Care:

...

21. The following transplants, when Medically Necessary: Cornea, Kidney, Lung, Liver, Heart, **Heart-Lung, Heart Valves** Pancreas{, and Bone Marrow (for the treatment of Leukemia, lymphoma, neuroblastoma, aplastic anemia, genetic disorders (SCID and WISCOT Alldrich))}.
22. **Allogenic bone marrow transplants.**
23. **Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma Neuroblastoma, Aplastic, Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer when approved in advance by Us, if You are participating in a National Cancer Institute sponsored Clinical trial.**

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office **[, Health Center]** or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.

...

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary **and Appropriate** and only to the extent of the covered benefit as defined above.

(e) **ALCOHOLISM BENEFITS.** The following Services are covered when rendered by a Participating Provider at Provider's office **[, Health Center]** or at a Participating Substance Abuse Center upon prior written referral by your Primary Care Physician.

...

3. Court-ordered alcohol admissions are not covered unless Medically Necessary **and Appropriate** and only to the extent of the covered benefit as defined above.

(f) **MEDICAL EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by your Primary Care Physician in the event of an as determined by Us.

1. Your Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to your health, you shall call your Primary Care Physician **[or Health Center] [or Us]** prior to seeking emergency treatment.

...

3. In the event you are hospitalized in a Non-participating {facility} **Facility**, coverage will only be provided until you are medically able to travel or to be transported to a Participating {facility} **Facility**. If you elect to continue treatment with Non-participating providers, We shall have no responsibility for payment beyond the date you are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary and Appropriate, We will cover the reasonable cost as determined by us. Reimbursement may be subject to payment by you of all copayments which would have been required had similar benefits been provided during office hours and upon prior written referral to Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after you have been admitted to a {facility} **Facility** as the result of a Medical Emergency shall require prior written referral or you shall be responsible for payment.
5. The copayment for an emergency room visit will not apply in the event that you were referred for such visit by your Primary Care Physician for services that could have been rendered in the Primary Care Physician's office or if you are admitted as an inpatient to the hospital as a result of the Medical Emergency.

(h) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by your Primary Care Physician.

1. Speech therapy, Physical therapy, occupational therapy and cognitive therapies are covered for non-chronic conditions and acute {illnesses} **Illnesses** and {injuries} **Accidental Injuries** upon referral to a Participating Provider by your Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of illness or injury, beginning with the first day of treatment, provided that your Primary Care Physician certifies in writing that the treatment will result in a significant improvement of your condition within this time period and treatment is approved in writing by Us.
2. Chelation therapy, chemotherapy treatment, dialysis treatment, infusion therapy and radiation therapy.

(i) **HOME HEALTH BENEFITS.** The following Services are covered when rendered by a **Participating Provider, including but not limited to a** Participating Home Health Agency, as an alternative to hospitalization and are approved and coordinated in advance by us upon the prior referral of your Primary Care Physician.

...

VI. EXCLUSIONS

THE FOLLOWING ARE *NOT* COVERED SERVICES UNDER THIS POLICY.

...

{Fluoroscopy or x-ray examinations without film.}

...

[Prescription Drugs: We do not cover an initial prescription or refill that exceeds the lesser of: the amount prescribed by the Participating Provider and the amount shown below that applies to the Prescription Drug:

(a) For a Prescription Drug which is an oral contraceptive drug or a Maintenance Drug: a ninety (90)day supply.

(b) For all other Prescription Drugs:

(i) a thirty (30) day supply of tablets, capsules, and liquids to be taken orally; or

(ii) sixty (60) milliliters or one (1) manufacturer's smallest standard package size of topical solution or lotion;

(iii) a fourteen (14) day supply of rectal or vaginal medication (e.g., suppositories, creams, ointment, enemas, etc.); or

(iv) one (1) manufacturer's standard package unit containing no more than sixty (60) grams of topical ointment or cream; or

(v) one (1) vial containing no more than fifteen (15) milliliters of any otic or opthalmic product; or

(vi) two (2) manufacturer's smallest standard package units of a nasal or oral inhaler; or

(vii) three(3) manufacturer's standard (10) milliliter vials of insulin.

We also do not cover prescription refills that are:

(a) dispensed more than 12 months after the day of the Provider's original order of the Prescription Drugs; or

(b) dispensed more than 10 days before the date the prior prescription or refill would be consumed when taken as directed.

A Prescription Drug that is prescribed for injectable use, other than injectable insulin on prescription only, is not covered.

Allergy and biological sera, therapeutic devices or appliances are not covered as Prescription Drugs.]

Private-Duty Nursing, except as provided for under Home Health Care.

Rest or convalescent cures.

Room and board charges for any period of time during which You were not physically present in the room.

Routine Foot Care **except when determined by Us to be Medically Necessary and Appropriate due to an Accidental Injury or Illness which causes life or limb to be threatened if Routine Foot Care is not administered.**

Self-administered services such as: biofeedback, patient-controlled analgesia, related diagnostic testing, self-care and self-help training.

Services or supplies:

—eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not You assert Your rights to obtain this coverage or payment for these services;

—for which a charge is not usually made, such as a {Doctor} **Practitioner** treating a professional or business associate, or services at a public health fair;

—for which You would not have been charged if You did not have health care coverage;

—for Your personal convenience or comfort, including, but not limited to, such items as TVs, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs;

—for which the Provider has not received a certificate of need or such other approvals as are required by law;

—furnished by one of the following members of Your family: spouse, child, parent, in-law, brother or sister;

—needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation;

—provided by or in a government hospital unless the services are for treatment: (a) of a non-service medical emergency; or (b) by a Veterans' Administration hospital of a non-service related Illness or Accidental Injury; or the hospital is located outside of the United States and Puerto Rico; or unless otherwise required by law.

—provided by or in any locale outside the United States, except in the case of a Medical **Emergency**;

—provided by a licensed pastoral counselor in the course of his **or her** normal duties as a pastor or minister;

{—provided by a social worker, except as otherwise stated in this Policy;}

—received as a result of: war, declared or undeclared; police actions; service in the armed forces or units auxiliary thereto; or riots or insurrection;

—rendered prior to Your Effective Date of coverage or after your termination date of coverage under this Policy;

—which are specifically limited or excluded elsewhere in this Policy;

—which are not Medically Necessary and Appropriate;

—due to an Accidental Injury or Illness

—for which You are not legally obligated to pay.

...

{TMJ Syndrome: dental treatment of TMJ Syndrome, including but not limited to crowns, bridgework and intraoral prosthetic devices.}

Transportation; travel.

{Vision therapy, vision or visual acuity training, orthoptics and pleoptics.}

...

VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VIII. {COORDINATION OF BENEFITS}
BENEFITS FROM OTHER PLANS

SERVICES AVAILABLE UNDER OTHER POLICIES

{If Covered Services are provided under this Policy and these same Covered Services or expenses are covered under Other Valid Coverage, Our liability will be reduced so as not to exceed Our pro-rata share of the total coverage available. If We reduce Our liability on a pro-rata basis, We will also return a pro-rata share of the Premium to You.

To determine Our pro-rata Payment, We will:

(a) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under Other Valid Coverage of which We had notice;

(b) add together Our benefits (calculated without reference to Other Valid Coverage) and the amount(s) payable (for the same Covered Services) under all Other Valid Coverage (whether or not We had notice);

(c) divide the total in (1) by the total in (2) to calculate a percentage; and

(d) multiply the percentage calculated in step (3) by the reasonable cash value of the Covered Charges; the result is Our payment.

"Other Valid Coverage" means coverage, other than Ours, provided on an individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, "the amount(s) payable under Other Valid Coverage" shall be equal to the amount which the services rendered would have cost in the absence of such coverage.}

This provision applies to all Covered Services and Supplies under this Policy if You have Other Valid Coverage. The purpose of this provision is to make sure You do not collect more in benefits than You incur in charges.

If You have Other Valid Coverage, Your Coverage under this Policy is secondary and Your coverage under the Other Valid Coverage is primary. This means the Other Valid Coverage pays Covered Charges or provides Covered Services and Supplies first and this Policy pays only any remaining unpaid Covered Charges. Neither plan pays more than it would have without this provision.

In recognition of the benefits under this Policy being secondary and thus reduced, the premium You pay for this Policy is reduced to actuarially reflect the benefit reduction. In the event We are not aware You have Other Valid Coverage at the time this Policy is issued to You, We will only reduce Your premium only after We do receive notice of the Other Valid Coverage. We will not refund any premium amounts previously paid.

Should You cancel the Other Valid Coverage, Your coverage under this Policy will become primary and Your premium amount adjusted accordingly. In the event You receive Covered Services and Supplies under this Policy while this Policy is providing primary coverage and you are paying a reduced premium based on this Policy providing secondary coverage, You are obligated to Us for the full premium amount.

"Other Valid Coverage" means coverage, other than Ours, provided on a group or individual basis, by insurance companies, hospital or medical service organizations, health maintenance organizations, union welfare plans, employer or employee benefit organizations, and employers; it also includes automobile medical payments insurance (other than that required by New Jersey law). If Other Valid Coverage is on a provision of service basis, the amount(s) payable under Other Valid Coverage shall be equal to the amount which the services rendered would have cost in the absence of such coverage.

Our Right To Certain Information: In order to coordinate benefits, We need certain information. You must supply Us with as much of that information as You can. But if You cannot give Us all the information We need, We have the right to get this information from any source. If another insurer needs information to apply its coordination provision, We have the right to give that insurer such information. If We give or get information under this section We cannot be held liable for such action. When payment that should have been made by this Policy, but was made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

XI. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us or a Covered Person.

If a Covered Person makes a claim to Us for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Accidental Injury.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We paid benefits.

The repayment will be equal to the amount of benefits paid by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

We shall require the return of health benefits paid for an Illness or Accidental Injury, up to the amount a Covered Person receives for that Illness or Accidental Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Accidental Injury, resulting from the negligence, intentional act, or no-fault tort liability of a Third Party.

{IX.} *X.* GENERAL PROVISIONS

...

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Policy will reduce Your Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made. premium adjustments that involve returning an unearned premium to You will be limited to the twelve-month period before We received satisfactory evidence that such adjustment should be made.

If You misstate {your} **Your** age or any other relevant fact and the Premium is affected, a fair adjustment of Premiums will be made. If such misstatement affects the amount of coverage, the true facts will be used in Determining what coverage is in force under this Policy.

...

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, {facility} **Facility** or agency is our agent or employee. Neither HMO nor any employee of HMO is an agent or employee of any Participating Provider or other provider, institution, {facility} **Facility** or agency.
2. Neither the Policyholder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Policy.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Policyholder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by a duly authorized officer of HMO.

...

MEDICAL NECESSITY

Members will receive designated benefits under the Policy only when Medically Necessary **and Appropriate**. We may determine whether any benefit provided under the Policy was Medically Necessary **and Appropriate**, and We have the **option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity and appropriateness** are subject to review by the Quality Assessment Committee of HMO or its physician designee. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Policy that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Policy.

...

{REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor HMO, or any Participating Provider will have further responsibility to provide any of the benefits available under this Policy for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure. The foregoing is not applicable if such refusal is according to a properly executed advance directive or living will for medical treatment.}

NON-COMPLIANCE WITH MEDICALLY NECESSARY AND APPROPRIATE TREATMENT

A Member has the right under New Jersey law to refuse procedures, medicines, or courses of treatment. A Member has the right to participate in decision-making regarding the Member's care. Further, a Member may, for personal, religious or cultural reasons disagree or not comply with procedures, medicines, or courses of treatment deemed Medically Necessary and Appropriate by a Participating Physician. A Member who refuses procedures, medicines or courses of treatment has the right to seek a second opinion from another Participating Physician. If such Participating Physician(s) believe(s) that the recommended procedures, medicines, or courses of treatment are Medically Necessary and Appropriate, the Participating Physician shall inform the Member of the consequences of not complying with the recommended procedures, medicines, or courses of treatment and seek to resolve the disagreement with the Member and or the Member's family or other person acting on the Member's behalf. If the Member refuses to comply with recommended procedures, medicines, or courses of treatment, We will notify the Member in writing that We will not provide further benefits or services for the particular condition or its consequences. The Member's decision to reject Medically Necessary and Appropriate procedures, medicines, or courses of treatment is subject to the Grievance Procedure and We will continue to provide all benefits covered by the Policy during the pendency of the Grievance Procedure. We reserve the right to expedite the Grievance Procedure. If the Grievance Procedure results in a decision upholding position of the Participating Physician(s) and the dispute is unresolved, We will have no further responsibility to provide any of the benefits available under this Policy for treatment of such condition or its consequences unless the Member asks, in writing and within 7 days of being informed of the result of the Grievance Procedure, to terminate this Policy in accordance with Section IX. In such event, We will continue to provide all benefits covered by this Policy for 30 days or until the date of termination, whichever comes first, and We and the Participating Physician will cooperate with the Member in facilitating a transfer of care.

REFUSAL OF LIFE-SUSTAINING TREATMENT

A Member has the right under New Jersey law to refuse life sustaining treatment. A Member who refuses life sustaining treatment remains eligible for all benefits including Home Health and Hospice benefits in accordance with this Policy. We will follow a Member's properly executed advance directive or other valid indication of refusal of life sustaining treatment.

...

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your Dependents must select a Primary Care Physician [{or} **and a** Health Center].

You select a Primary Care Physician from Our {Doctor} **Practitioners** Directory; this choice is solely Yours. However, We cannot guarantee the availability of a particular {Doctor} **Practitioner**. If the Primary Care Physician initially selected cannot accept additional patients, You will be notified and given an opportunity to make another Primary Care Physician selection.

...

STATEMENTS

No statement will {avoid} **void** the coverage, or be used in defense of a claim under this Policy, unless it is contained in a writing signed by You, and We furnish a copy to You or Your beneficiary.

All statements will be deemed representations and not warranties.

...

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

During or at End of Grace Period—Failure to Pay Premiums: If any Premium is not paid by the end of its grace period, the Policy will end when that period ends. But You may write to Us, in advance, to ask that the Policy be terminated at the end of any period for which Premiums have been paid. Then the Policy will end on the date requested.

{This Policy is issued for a term of one year from the Effective Date. All Benefit Periods and Benefit Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time.}

This Policy will be renewed automatically each year on the Anniversary Date, unless one of the following circumstances occur:

(a) nonpayment of Premiums;
(b) fraud or misrepresentation by You or Your Dependents;
(c) termination of Your eligibility or, with respect to Your Dependent, Your Dependent's eligibility;
(d) You become eligible to participate in a Group Health Benefits Plan which provides the same or similar coverage;
(e) non-renewal as authorized by the Board.

Immediate cancellation will occur if You commit fraudulent acts or make misrepresentations with respect to coverage of You and Your Dependents.

...

EXHIBIT M

PPO STANDARD PLAN PROVISIONS

[III. PREFERRED PROVIDER ORGANIZATION PROVISIONS

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. [In addition to an identification card,] the Covered Person will periodically be given up-to-date lists of [XYZ Health Care] Network Providers.

Use of the network is strictly voluntary, but We generally pay a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, We generally pay a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care] Network Provider orders the services and supplies). Of course, a Covered Person is always free to be treated by any Provider by any Provider or Facility. And, he or she is free to change Providers or Facilities at any time.

A Covered Person may use any [XYZ Health Care] Network Provider. [He or she just presents his or her XYZ Health Care Network identification card to the XYZ Health Care Network Provider or Facility furnishing covered services or supplies. Most XYZ Health Care Network Providers and Facilities will prepare any necessary claim forms for him or her, and submit the forms to Carrier.] The Covered Person will receive an explanation of any insurance payments made by this Policy. [And if there is any balance due, the [XYZ Health Care] Network Provider or Facility will bill You.]

This Policy also has utilization review features. See the Utilization Review section for details.

What We pay is subject to all the terms of this Policy. You should read this policy carefully and keep it available when consulting a Provider.

See the Schedule of Benefits for specific benefit levels, payment rates and payment limits.

If You have any questions after reading this Policy, You should call Us [Claim Office at the number shown on your identification card.]

EXHIBIT N

POS STANDARD PLAN PROVISIONS

III. POINT OF SERVICE PROVISIONS

A. Definitions

***Primary Care Practitioner (PCP)* means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization We will supply a list of [PCPs] who are members of the [XYZ] Provider Organization to You.**

***Provider Organization (PO)* means a network of health care Providers located in a Covered Person's Service Area.**

***Network Benefits* means the benefits shown in the Schedule which are provided if the [Primary Care Practitioner] provides care, treatment, services, or supplies to the Covered Person or if the [Primary Care Practitioner] refers the Covered Person to another Provider for such care, treatment, services, or supplies.**

***Out-of-Network Benefits* means the benefits shown in the Schedule of Benefits which are provided in the [Primary Care Practitioner] does not authorize the care, treatment, services, and supplies.**

***Service Area*—means the geographical area which is served by the Practitioner in the [XYZ] Provider Organization.**

B. Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This policy requires that the Covered Person uses the services of a [PCP], or be referred for services by a [PCP], in order to receive Network Benefits.

C. The [Primary Care Practitioner (PCP)]

The [PCP] will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The [PCP] must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized referral form from his or her [PCP] before he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the covered Person does not comply with these requirements, he or she may only be eligible for Out-of-Network Benefits.

We provide Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her [PCP]. We pay Out-of-Network Benefits when covered services and supplies are not authorized by the [PCP]. If services or supplies are obtained from [XYZ] Providers but they are not authorized by the [PCP], the Covered Person may only be eligible for Out-of-Network Benefits.

A Covered Person may change his or her [PCP] to another [PCP] [once per month]. He or she may select another [PCP] from the list of Practitioner's and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a [PCP], he or she must present his or her ID card and pay the Copayment. When a Covered Person's [PCP] refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Copayment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to Us.[PCP]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her [PCP]. She must obtain authorization from her [PCP] for any services beyond a routine exam and tests.]

D. Out-of-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her [PCP], he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's [PCP], whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-of-Network Benefits.

E. Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her [PCP] within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed [by the [PCP]]. We will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the [PCP] must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Perso can return to the PO Service Area.

F. Utilization Review

This Policy has utilization review features. See the Utilization Review section of this Policy.

G. Benefits

The Schedule shows Network Benefits, Out-of-Network Benefits, and Copayments applicable to the Point of Service arrangement.

What We pay is subject to all the terms of this Policy.

For *Continued Confinement* as an Inpatient beyond the time authorized, You or Your Provider must contact us within hours prior to the preapproved discharge date for additional authorization.

EXHIBIT O

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan A when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/Network Provider[] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO UNLIMITED LIFETIME MAXIMUM.

FACILITY BENEFIT—30 days Inpatient Hospital care.

In-Network [ ]
Out-of-Network [ ]

COINSURANCE:

FACILITY

In-Network [ ]
Out-of-Network [ ]

PRACTITIONER'S SERVICES

In-Network [ ]
Out-of-Network [ ]

NOTE: The Coinsurance Amounts cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Copayments

CASH DEDUCTIBLES:

INPATIENT (separate)—$250/day, $1,250 per Period of Confinement/Covered Person; max. of two Inpatient Deductibles/Covered Person.

In-Network [ ]
Out-of-Network [ ]

OTHER COVERED CHARGES—$250/Covered Person, $500/family.

In-Network [ ]
Out-of-Network [ ]

PRIMARY CARE SERVICES—$100/Covered Person, $300/family. Not subject to Deductibles and Coinsurance.

In-Network [ ]
Out-of-Network [ ]

[OTHER—LIST]

In-Network [ ]
Out-of-Network [ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO SECTIONS OF THIS POLICY CALLED "COVERED CHARGES" AND "CHARGES COVERED WITH SPECIAL LIMITATIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE ELIGIBLE FOR BENEFITS.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

EXHIBIT P

PPO/POS SCHEDULE

Example Schedule of Benefits for Plan B through E when offered as a PPO/POS

[III. SCHEDULE OF BENEFITS

Services and Supplies provided by a [Primary Care Physician] [Network Provider] [or through a Referral by Your Primary Care Physician/Network Provider] are paid at the In-Network level of benefits.

Payment under this Policy will be provided at the Out-of-Network level of benefits if [Your] [Primary Care Physician] [Network Provider] [has not provided or coordinated Your Care before a Covered Charge is incurred].

BENEFITS FOR COVERED CHARGES UNDER THIS POLICY [ARE SUBJECT TO ALL DEDUCTIBLES, COPAYMENTS AND COINSURANCE, AND] ARE [IS] DETERMINED PER BENEFIT PERIOD BASED ON OUR ALLOWANCE, UNLESS OTHERWISE STATED.

ALL BENEFITS SUBJECT TO [AN UNLIMITED (PLANS C-E)] [$1,000,000 (PLAN B)] PER LIFETIME MAXIMUM.

FACILITY BENEFIT—365 days Inpatient Hospital care.

In-Network [ ]
Out-of-Network [ ]

COINSURANCE:

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE

In-Network [ ]
Out-of-Network [ ]

OTHER COVERED CHARGES

In-Network [ ]
Out-of-Network [ ]

COINSURANCE CAP—[Insert Appropriate Plan Amounts per Covered Person and per Family]

NOTE: The Coinsurance Caps cannot be met with:

- Non-Covered Expenses
- Cash Deductibles
- Coinsurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Copayments

CASH DEDUCTIBLE—[Insert Appropriate Plan Amounts/Covered Person]
[Insert Appropriate Plan Amounts/family]

EMERGENCY ROOM COPAYMENT (Credited toward Inpatient admission if admission occurs within 24 hours as the result of the Medical Emergency)

In-Network [ ]
Out-of-Network [ ]

HOME HEALTH CARE—Unlimited days, if preapproved.

In-Network [ ]
Out-of-Network [ ]

HOSPICE CARE—Unlimited days, if preapproved.

In-Network [ ]
Out-of-Network [ ]

MENTAL OR NERVOUS CONDITIONS AND SUBSTANCE ABUSE—Up to $5,000/Benefit Period combined Inpatient and Outpatient.

BENEFIT MAXIMUMS—Per Lifetime maximum of $25,000 combined Inpatient and Outpatient.

In-Network [ ]
Out-of-Network [ ]

PRESCRIPTION DRUGS—Subject to annual deductible and coinsurance.

In-Network [ ]
Out-of-Network [ ]

PRIMARY CARE SERVICES
In-Network [ ]
Out-of-Network [ ]
SKILLED NURSING CARE
In-Network [ ]
Out-of-Network [ ]
THERAPEUTIC MANIPULATIONS—**30 visits/Covered Person.**
In-Network [ ]
Out-of-Network [ ]
THERAPY SERVICES—**30 visits/Covered Person/Therapy Services except: Radiation Therapy, Chemotherapy, Chelation, Dialysis and Respiration Therapy (which are covered as any other Illness).**
In-Network [ ]
Out-of-Network [ ]
[OTHER—LIST]
In-Network [ ]
Out-of-Network [ ]

NOTE: OUR PAYMENTS, AS NOTED ABOVE, WILL BE REDUCED FOR NONCOMPLIANCE WITH THE UTILIZATION REVIEW PROVISIONS CONTAINED IN THIS POLICY. READ THESE PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS POLICY CALLED "EXCLUSIONS" TO SEE WHAT SERVICES AND SUPPLIES ARE NOT ELIGIBLE FOR BENEFITS.]

(a)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Proposed Amendments: N.J.A.C. 11:21-1.2, 1.3, 2.2, 7.1, 7.2, 7.3, 7.5 through 7.9, 7.12, 7.13, and Appendix Exhibits N, O, Q, R, S and T

Proposed New Rules: N.J.A.C. 11:21- 3A

Proposed Repeal: N.J.A.C. 11:21-7A

Authorized By: New Jersey Small Employer Health Benefits Program Board, Maureen E. Lopes, Chair.

Authority: N.J.S.A. 17B:27A-17 et seq., as amended by N.J.S.A. 17B:27A-51 and P.L. 1994, c.11.

Proposal Number: PRN 1994-465.

Submit written comments by August 12, 1994 to:
Kevin O'Leary, Executive Director
New Jersey Small Employer Health Benefits Program
20 West State Street, 10th Floor
CN 325
Trenton, NJ 08625

The agency proposal follows:

Summary

The proposed new rule and amendments are being promulgated in accordance with N.J.S.A. 17B:27A-51, which provides a special procedure whereby the Small Employer Health Benefits Program ("SEH") Board may adopt certain actions. Pursuant to this procedure, the Board is required to publish notice of its intended action in three newspapers of general circulation, which notice shall include procedures for obtaining a detailed description of the intended action and the time, place and manner by which interested persons may present their views regarding the intended action. Notice of the intended action also is required to be sent to affected trade and professional associations, carriers, and other interested persons who may request such notice.

Concurrently, the Board is required to forward the notice of the intended action to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. The Board must provide a minimum 20-day period for all interested persons to submit their written comments on the intended action to the Board. The Board may adopt its intended action immediately upon the close of the specified comment period by submitting the adopted action to the OAL. If the Board elects to adopt the action immediately upon the close of the comment period, it shall nevertheless respond to the comments timely submitted within a reasonable period of time thereafter. The Board shall prepare a report for public distribution, and publication by the OAL in the New Jersey Register. The report shall include the list of commenters, their relevant comments and the Board's responses. Due to the expedited nature of this process, a proposed rule may have been adopted before it appears as a proposal in the New Jersey Register.

On April 4, 1994, the Governor signed P.L. 1994, c.11 ("the Act"). The Act significantly amended P.L. 1992, c.162 ("the SEH Act"), the law that created the SEH Program, which regulates health insurance coverage offered to employers with two to 49 eligible employees. The Act substantially changed the SEH Program, with respect to the health benefits plans that may be offered to small employers and the conditions that apply to such plans. In order to implement the Act, the SEH Board proposes amendments to N.J.A.C. 11:21-1, 2, 3A, 7, 7A and Exhibits N, O, Q, R and S of the Appendix to N.J.A.C. 11:21.

In N.J.A.C. 11:21-1.1, the definition of "eligible employee" has been changed in conformance with the Act to exclude employees who are participating in an employee welfare arrangement pursuant to a collective bargaining agreement. Such employees, therefore, will no longer be counted for purposes of determining whether an employer is a "small employer" or whether minimum participation requirements have been met. The definition of "health benefits plan" has been modified in conformance with the Act to clarify that all hospital confinement or other supplemental limited benefit insurance is excluded. The definition of "multiple employer arrangement" has been amended to conform with the Act to clarify that the term means an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk as determined by the Commissioner of Insurance. A definition of "supplemental limited benefit insurance" has been added, pursuant to the Act. N.J.A.C. 11:21-1.3 has been amended to reflect the new mailing address of the Executive Director of the SEH Program Board.

The definitions enumerated above are repeated, and similarly amended, in N.J.A.C. 11:21-2.2, the SEH Plan of Operation.

The proposed new rules, N.J.A.C. 11:21-3A, set forth the rules that apply to issuance, renewal and continuation of health benefits plans issued to small employers prior to January 1, 1994 and which remained in effect on February 28, 1994. The Act changed a provision of the SEH Act which would have required all small employers to convert, beginning on March 1, 1994, to one of the five health benefits plans, and HMO plan, formulated by the Board and approved by the Commissioner of Insurance. The Act has delayed the so-called "mandatory conversion" for two years. Because different rules and conditions apply to different types of health benefits plans, a new subchapter was necessary to regulate the small employer health insurance market while it is in transition toward a standardized, reformed market over the next three years.

A definition of "anniversary date" and "12-month anniversary date" has been established in N.J.A.C. 11:21-3A.2 to ensure that all carriers understand when and for how long non-standard health benefits plans may be issued, continued or renewed. The term "non-standard health benefits plan" describes a health benefits plan issued to small employers prior to January 1, 1994 and which remained in effect on February 28, 1994. "Standard health benefits plan" describes one of the health benefits plans formulated by the SEH Board and approved by the Commissioner. The term "health benefits plan" has been added to describe both a non-standard and standard health benefits plan. The SEH Board needed the additional definitions because different conditions and rules apply to different health benefits plans. Wherever it appears, the term "small employer" has been deleted where it precedes "health benefits plan" so that terms are used consistently and accurately.

N.J.A.C. 11:21-3A.3 provides that, during the period commencing with the enactment of the Act and ending September 13, 1994 (60 days after the effective date of N.J.A.C. 11:21-7.15), the rule establishing permissible rating factors for modified community rating of health benefits plans, a carrier, association, multiple employer arrangement, or out-of-State trust shall renew or continue a non-standard health benefits plan at the option of the small employer as provided in the Act. Beginning on its first anniversary date on or after September 11, 1994, a non-standard health benefits plan must conform with the many of the requirements of SEH Act, including: guaranteed issuance; limitations on pre-existing condition waiting periods; guaranteed renewal; minimum participation and employer contributions; modified community rating; and continuation of coverage. A small employer may renew a non-standard health benefits plan on each anniversary date that occurs between February 28, 1994 and February 28, 1996, and the plan may remain in effect until the end of the contract year occuring after the

last permissible renewal. A non-standard health benefits plan may not be amended, except as required to comply with the specified provisions of the SEH Act or for the purpose of changing deductibles or copayments of that plan. A non-standard health benefits plan must be filed in accordance with regulations promulgated by the Commissioner of Insurance.

N.J.A.C. 11:21-3A.4 provides that non-standard health benefits plans that were converted to standard health benefits plans on an anniversary date that occurred between March 1, 1994 through April 4, 1994 were permitted to be reinstated within 60 days of the anniversary date upon written notice to the carrier and may be renewed under the same conditions as apply to non-standard health benefits plans generally.

N.J.A.C. 11:21-3A.5 provides that associations, multiple employer arrangements, and out-of-State trusts may issue non-standard health benefits plans that were available for purchase to their members as of December 31, 1993, subject to the conditions described above with respect to renewal and continuation of non-standard health benefits plans. A carrier, acting along, may not issue non-standard health benefits plans. Associations, multiple employer arrangements, and out-of-State trusts may issue non-standard health benefits plans only to members, but on a guaranteed issue basis, without regard to health status of employees or their dependents. To the extent such coverage is offered to new employees of the small employer member, associations, multiple employer arrangements, and out-of-State trust may not discriminate between employers or between new employees.

N.J.A.C. 11:21-3A.6 makes clear that no non-standard health benefits plan may remain in effect beyond the anniversary date that occurs after February 28, 1996 and on or before February 28, 1997. Carriers are required to give small employers 60 days notice of cancellation and provide information about standard health benefits plans available to replace the cancelled coverage.

N.J.A.C. 11:21-3A.7 provides for penalties for violations of the subchapter.

The Board has repeated in N.J.A.C. 11:21-7.2 the definitions of "non-standard health benefits plan," "standard health benefits plan," and "health benefits plan" and inserted them, where appropriate throughout subchapter 7, to reflect the continuation of non-standard health benefits plans provided in subchapter 3A.

N.J.A.C. 11:21-7.3 has been amended to cross reference subchapter 3A. N.J.A.C. 11:21-7.3(e) has been amended to clarify that a small employer carrier may continue to offer coverage to part-time employees of an employer that provided such coverage to part-time employees prior to January 1, 1994 when the carrier renews or reinstates the health benefits plan under N.J.A.C. 11:21-3A. Employees that are hired or become part-time employees after January 1, 1994 may also be covered. N.J.A.C. 11:21-7.3(f) has been amended to clarify that a small employer carrier may continue to offer coverage to retired employees of an employer that provided such coverage to retired employees prior to January 1, 1994 when the carrier renews or reinstates the health benefits plan under N.J.A.C. 11:21-3A. Employees who retire after January 1, 1994 may also be covered. N.J.A.C. 11:21-7.3(g) has been amended to clarify that a small employer carrier may continue to offer coverage to part-time or retired employees of an employer that becomes a small employer after January 1, 1994 when the carrier renews or reinstates the health benefits plan under N.J.A.C. 11:21-3A. Employees who are hired part-time, become part-time employees, or retire after January 1, 1994 also may be covered. The Board has determined, and will promulgate rules in the future, that carriers that choose to continue to cover part-time and retired employees as permitted under N.J.A.C. 11:21-7.3(e), (f), or (g) will not be eligible for reimbursement of losses attributable to claims by part-time and retired employees. Therefore, carriers must segregate such claims for reporting purposes.

N.J.A.C. 11:21-7.5 has been amended to clarify that the rule applies to standard health benefits plans.

N.J.A.C. 11:21-7.6 has been amended to clarify that a carrier or carriers offering a health benefits plan to a small employer should count employees participating in an HMO plan or plans, if more than one HMO plan is offered, and employees participating in an indemnity plan when calculating the small employer's participation rate. For example, if half of the eligible employees of a small employer enrolled in an HMO plan offered by one carrier and the other half enrolled in an indemnity plan offered by another carrier, each carrier should view the employer as having a participation rate of 100 percent. The change reflects only a clarification of the SEH Act.

N.J.A.C. 11:21-7.7, 7.8, 7.9 and 7.12, regarding contributions requirements, pre-existing condition exclusion limitations, effective dates of coverage, and guaranteed renewals, respectively, are being proposed for amendment to clarify that each provision is applicable to both standard and nonstandard health benefits plans. N.J.A.C. 11:21-7.8(b) has been further amended to implement a change in the SEH Act made by P.L. 1993, c.162 to provide that a small employer carrier shall waive any time period applicable to a preexisting condition limitation period for the period of time an individual was covered under any previous hospital and medical expense insurance policy or certificate, or health hospital or medical service corporation contract or certificate, or health maintenance organization subscriber contract or certificate delivered or issued for delivery in the United States, as long as the employee's condition was covered by the prior plan. The amendment is intended to clarify that an employee with prior coverage under an individual health benefits plan, or other health insurance coverage issued outside of New Jersey, would receive credit for the time covered toward any pre-existing condition limitation a carrier might otherwise impose. However, if a condition was not covered by the employee's prior health coverage, a carrier could impose a pre-existing condition waiting period on the employee with respect to that condition.

N.J.A.C. 11:21-7.13 has been amended to require carriers to report separately information about issuance and inforce standard and non-standard health benefits plans on a quarterly and annual basis. Annually, carriers will be asked to report the two digit Major Group of the Standard Industrial Classification of small employers that apply for health benefits plans. The new quarterly reporting requirement is less comprehensive than the annual report. The SEH Board believes this information is essential to evaluate and make any determinations about the effectiveness of reforms in the small employer market.

Subchapter 7A has been deleted in its entirety because its provisions dealing with conversion conflict with the Act.

The Application for a Small Employer Health Benefits Policy, Exhibit N in the Appendix to N.J.A.C. 11:21, has been amended as follows: in section I, line 7, the partial definition of "eligible employee" has been deleted and a reference to a more complete definition has been added; in section I, the request for information with regard to affiliates, subsidiaries, or branches has been amended to include a statement that such information must be included for participation purposes (to determine participation rates).

The New Jersey Small Employer Certification, Exhibit O in the Appendix to N.J.A.C. 11:21, has been amended as follows: a change has been made to include an additional status for employees participating in an employee welfare arrangement pursuant to a collective bargaining agreement to reflect that such employees shall not be counted for purposes of participation; a corresponding statement that such employees shall not be counted has been added to the "Group Health Benefits Policy Participation section; and two fields have been added to capture "job title" and "work location" information, which will be used to verify employment status.

The Small Group Employer Benefits Enrollment Form and Health Statement, Exhibits Q and S of the Appendix to N.J.A.C. 11:21, have been amended as follows: the word "Health" has been deleted and replaced with "Pre-existing Conditions" in the title of Exhibit Q, and throughout the form wherever those terms appear, to reflect that health status will not be taken into account for rating purposes, but only to determine whether a preexisting condition limitation may apply; in Section II, information on place of birth, height, and weight, will not be requested; in section III, which is Exhibit S, the word "health" in the title will be changed to "pre-existing conditions," and language will be added immediately thereunder to reflect that the questions about health may only be used to determine whether an employee has a preexisting condition, not for issuance or rating. With respect to specific conditions enumerated in 1(a) through (n), these questions are now variable at the carrier's option and a statement has been added to restrict the time period to which the questions pertain to the six months prior to the effective date of the group coverage. Question 2, relating to the AIDS virus, has been deleted. Question 3 has been renumbered, a statement has been added to restrict the time period to which the questions pertain to the six months prior to the effective date of the group coverage, and the question about the use of tobacco products has been deleted. In section IV of Exhibit Q, the term "premiums" has been deleted and replaced by "contributions." Under the paragraph titled "Authorization" in Section IV, the term "the Medical Information Bureau" has been deleted. The paragraph titled "MIB" Disclosure Notice has been deleted.

Conforming changes are proposed on the HMO enrollment form, Exhibit R, and The Small Employer Health Benefits Waiver of Coverage form, Exhibit T, to reflect the changes to Exhibits Q and S.

Social Impact

The proposed amendments to N.J.A.C. 11:21-1, 2, and 7, the repeal of N.J.A.C. 11:21-7A and proposed new rules N.J.A.C. 11:21-3A all implement the Act by permitting the issuance, renewal or continuation of health benefits plans issued to small employers prior to January 1, 1994 and which remained in effect on February 28, 1994. The proposed rule changes implement the Act's delay of the requirement that all small employers convert, beginning on March 1, 1994, to one of the five health benefits plans, and HMO plan, formulated by the Board and approved by the Commissioner of Insurance.

The amendments, new rules and repeal will affect all carriers, associations, multiple employer arrangements and out-of-State trusts issuing or renewing health benefits plans to New Jersey small employers by allowing them, with restrictions, to issue, renew, reinstate, or continue non-standard health benefits plans. These entities will be required, beginning on the first anniversary date of a non-standard health benefits plan that occurs on or after September 11, 1994, to amend all non-standard health benefits plans to conform with the SEH Act's requirements of guaranteed issuance, limitations on pre-existing condition waiting periods, guaranteed renewal, minimum participation, modified community rating, and continuation of coverage.

Small employers wil be able to renew non-standard health benefits plans. While the benefits offered by those plans will not change, the rules that apply to their issuance and renewal, employee participation, employer contributions, limits on preexisting conditions, and rating will change. Pursuant to regulations already adopted by the SEH Board at N.J.A.C. 11:21-7.15, the factors used to rate non-standard health benefits plans will be restricted and may impact the cost of coverage. Some small employers may find a reduction in cost, while others experience an increase, due to modified community rating.

Employees of small employers will be affected to the extent that all health benefits plans must be offered on a guaranteed issue basis, not only to all small employers, but to all employees of small employers. Individual employees may not be excluded from coverage because of health status, age, gender, or any other factor. Employees who have been excluded from coverage by a non-standard health benefits plan in the past will now be eligible for coverage by their employer's plan. To the extent that changes to a non-standard health benefits plan increase or decrease the cost of that plan to the small employer policyholder, employees may see their contributions increase or decrease accordingly.

Economic Impact

The proposed amendments to N.J.A.C. 11:21-1, 2 and 7, the repeal of N.J.A.C. 11:21-7A and proposed new rules N.J.A.C. 11:21-3A will have an economic impact on all carriers, associations, multiple employer arrangements and out-of-State trusts issuing or renewing health benefits plans to New Jersey small employers by allowing them, with restrictions, issue, renew, reinstate, or continue non-standard health benefits plans. These entities would have been required by the SEH Act to convert their existing small group business to standard health benefits plans beginning on anniversary dates of March 1, 1994 and thereafter. The change in the law as a result of the Act is likely to result in continuation of many health benefits plans that might otherwise have been cancelled. However, beginning on the first anniversary date of a non-standard health benefits plan that occurs on or after September 11, 1994, all non-standard health benefits plans must conform with the SEH Act's requirements of guaranteed issuance, limitations on pre-existing condition waiting periods, guaranteed renewal, minimum participation, modified community rating, and continuation of coverage. Some additional costs are likely to be incurred in bringing non-standard health benefits plans into conformity with the Act.

Small employers will be able to renew non-standard health benefits plans. While the benefits offered by those plans will not change, the rules that apply to their issuance and renewal, rating, employee participation, employer contributions, and limits on preexisting conditions will change. Some small employers may find a reduction in cost, while others experience an increase in cost.

The economic impact on employees of small employers will depend on whether the employer experiences an increase or decrease in the cost of coverage. To the extent that employees will be guaranteed access to coverage, if an employer offers a health benefits plan, employees who had previously been forced to maintain separate coverage or pay for their own health care services, may experience a reduction in the cost of health care coverage. To the extent that the inclusion of all employees may result in an increase in the cost of the health benefits plan, employees who were previously covered may experience an increase in the cost of their contributions.

The amendments to the Exhibits in the Appendix to N.J.A.C. 11:21 will have a minimal administrative economic impact on carriers who are members of the SEH Program.

Regulatory Flexibility Analysis

The Board believes that all carriers subject to these rules have in excess of 100 employees or are located outside of the State of New Jersey. Therefore, a regulatory flexibility analysis is not required. However, to the extent that any carrier might be considered a small business under the terms of N.J.S.A. 52:14B-16 et seq., the Regulatory Flexibility Act, the following analysis would apply:

The proposed amendments to N.J.A.C. 11:21-1, 2 and 7, the repeal of N.J.A.C. 11:21-7A and the proposed new rules, N.J.A.C. 11:21-3A, will require carriers to amend all small employer policy forms, upon their anniversary dates, and to conform their operations (sales and administration) to the new requirements of the SEH Program. There will be capital costs involved in such compliance, in terms of printing, systems programming, staff and agent training, etc., but it is unlikely that any carrier would have to contract for outside professional services in order to comply. All of the required changes to a carrier's business fall within the normal functions a carrier performs in complying with any state insurance law or regulation. In general, the passage of the Act and these rules to implement it provide carriers with greater flexibility with regard to the health benefits plans they are permitted to offer. Carriers may elect to renew non-standard health benefits plans or to offer only standard plans. The amendments and rules expand existing annual reporting requirements and creates new quarterly reporting requirements for carriers issuing or renewing health benefits plans to New Jersey small employers. Specifically N.J.A.C. 11:21-7.13 will require separate reporting about standard and non-standard health benefits plans on both an annual and quarterly basis. In addition, the SIC code classification of small employers will be collected in the annual report. There is therefore, a reporting and compliance burden. The Board has sought the minimum amount of information it deems essential to judge the effectiveness of the SEH Program. An exemption from compliance, or lesser requirements, for a carrier that were a small business is not authorized by the SEH Act. In addition, it is essential that the SEH Program be administered uniformly, so an exemption would potentially undermine this important tenet of health insurance reform. With respect to expanded reporting requirements, information about carriers' sales of standard and non-standard health benefits plans is essential to the SEH Board; therefore, an exemption for small employers from the reporting requirements of the rules would result in the Board's collection of incomplete information about the effects of health insurance reform on the small employer market and impede the Board's efforts to make policy determinations.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in cursive brackets {thus}):

11:21-1.2 Definitions

Words and terms contained in this Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

...

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week {or}, work on a temporary or substitute basis **or are participating in an employee welfare arrangement pursuant to a collective bargaining agreement.**

...

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to

section 3 of the Act (N.J.S.A. 17B:27A-19), or any other similar contract, policy or plan issued to a small employer not explicitly excluded from the definition of health benefits plan. "Health benefits plan" excludes the following plans, policies, or contracts:

1. Accident only;
2. Credit;
3. Disability;
4. Long-term care;
5. Coverage for Medicare services pursuant to a contract with the United States government;
6. Medicare supplement;
7. Dental only or vision only;
8. Insurance issued as a supplement to liability insurance;
9. Coverage arising out of a workers' compensation or similar law;

10. Hospital confinement or other supplemental limited benefit insurance coverage;

[10.]**11.** Automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.); and

[11. Any group or group type supplemental hospital indemnity benefits program wherein the benefit does not exceed $250.00 per day. A hospital indemnity benefits program does not fail to meet the test therein so long as the benefit paid for the first two days of hospitalization does not exceed that which would be paid under the following formula:

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} \leq \$250]$$

...

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, {whether fully insured or not fully insured,} **under an insured plan purchased from a carrier in which the carrier assumes all or a substantial portion of the risk, as determined by the commissioner** and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

...

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

...

11:21-1.3 Communication with the Board

All written communications with the SEH Board shall be submitted to the SEH Board at the following address:

{Interim Administrator
New Jersey Small Employer Health Benefits
Program Board
SEH 1
c/o The Prudential Insurance Company of America
P.O. Box 4080
Iselin, New Jersey 08830}
New Jersey Small Employer Health Benefits
Program Board
20 West State Street
CN-325
Trenton, New Jersey 08625

...

SUBCHAPTER 2. NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM PLAN OF OPERATION

11:21-2.2 Definitions

The words and terms used in this Plan shall have the meanings set forth at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.3, or as further defined below:

...

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week {or}, work on a temporary or substitute basis **or are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement.**

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts; accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government. Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, **hospital confinement or other supplemental limited benefit insurance coverage,** automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70.

...

"Supplemental limited benefit insurance" means insurance that is provided in addition to a health benefits plan on an indemnity nonexpense incurred basis.

...

SUBCHAPTER 3A. NON-STANDARD HEALTH BENEFITS PLANS

11:21-3A.1 Purpose and scope

This subchapter establishes which non-standard health benefits plans may be issued, renewed, reinstated or continued pursuant to P.L. 1994, c.11, and specifies the standards which shall apply to the issuance, renewal, reinstatement or continuation of a non-standard health benefits plan.

11:21-3A.2 Definitions

Words and terms, when used in this subchapter, shall have the meanings as defined at N.J.S.A. 17B:27A-17 or N.J.A.C. 11:21-1.2 unless defined below or the context clearly indicates otherwise.

"Anniversary date" and "12-month anniversary date" means:

1. With respect to coverage of a small employer who has coverage other than as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract:

i. The annual 12-month renewal date following the initial effective date of coverage for that small employer under the policy or contract; or

ii. If such annual renewal date has been changed prior to April 4, 1994 and thus no longer is the same calendar date and with the initial effective date, the new annual renewal date;

2. With respect to coverage of a small employer as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract, wherein there is no common renewal date established for coverage of all such member small employers;

i. The annual 12-month renewal date following the initial effective date of coverage for that small employer; or

ii. If such annual renewal date has been changed prior to April 4, 1994, and thus no longer coincides with the initial effective date, the new annual renewal date; or

3. With respect to coverage of a small employer covered as a member of an association, multiple employer arrangement or out-of-State trust holding the master policy or contract, wherein there is a common renewal date established for coverage of all such small employers notwithstanding each small employer's initial effective date;

i. The common renewal date; or

ii. If the common renewal date has been changed prior to April 4, 1994, the new common renewal date.

"Non-standard health benefits plan" means a health benefits plan that was issued to cover one or more small employers by or through

a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board and set forth at N.J.A.C. 11:21-3.1.

11:21-3A.3 Renewal of non-standard health benefits plans

(a) During the period beginning on April 4, 1994 and ending on September 10, 1994, a carrier, association, multiple employer arrangement or out-of-State trust shall renew or continue a non-standard health benefits plan, at the option of the small employer policy or contract holder, pursuant to P.L. 1994, c.11.

(b) Beginning on September 11, 1994, a carrier, association, multiple employer arrangement or out-of-State trust shall renew or continue a non-standard health benefits plan, at the option of the small employer policy or contract, subject to the following:

1. On the first anniversary date of a small employer's coverage under the non-standard health benefits plan, the non-standard health benefits plan shall comply with the provisions of N.J.S.A. 17B:27A-18, 17B:27A-19b, 17B:27A-22, 17B:27A-23, 17B:27A-24, 17B:27A-25 and 17B:27A-27.

2. A small employer shall have the option to renew or continue a non-standard health benefits plan on any anniversary occurring between February 28, 1994 and February 28, 1996. Such non-standard health benefits plan may at the employer's option remain in effect until the end of the policy or contract year that begins on the 12-month anniversary date occurring on or before February 28, 1996.

3. The non-standard health benefits plan shall not be amended or modified, except as (b)1 above may require and except for the purpose of changing deductible or copayments for the non-standard health benefits plan.

4. The carrier, association, multiple employer arrangement or out-of-State trust shall file such renewed or continued non-standard health benefits plan with the Commissioner in accordance with regulations promulgated by the Department of Insurance.

11:21-3A.4 Reinstatement of non-standard health benefits plans

(a) A non-standard health benefits plan whose anniversary occurred March 1, 1994 through April 4, 1994 may be reinstated, at the option of the small employer policy or contract holder, by providing written notice to the carrier within 60 days of that anniversary date.

(b) A non-standard health benefits plan that is reinstated in accordance with subsection (a) may be renewed in accordance with and subject to the provisions of N.J.A.C. 11:21-3A.3.

11:21-3A.5 New issuance of non-standard health benefits plans

(a) A carrier shall not offer or issue a non-standard health benefits plan to a small employer except through an association, multiple employer arrangement or out-of-State trust in accordance with this section.

(b) An association, multiple employer arrangement or out-of-State trust shall not offer or issue a non-standard health benefits plan unless the non-standard health benefits plan:

1. Was available for purchase through the association, multiple employer arrangement or out-of-State trust to its members on December 31, 1993;

2. If issued during period beginning on April 4, 1994 and ending on September 10, 1994, complies with the requirements of N.J.A.C. 11:21-3A.3;

3. If issued on or after September 11, 1994, complies with the requirements of N.J.S.A. 17B:27A-18, 19b, 22, 23, 24, 25 and 27 upon the date of issue;

4. Shall not be amended or modified except as necessary to comply with (b)2 and 3 above, or for the purpose of changing deductible or copayments;

5. Shall remain available for renewal, at the option of the small employer through the 12-month anniversary date which occurs on or before February 28, 1996; and

6. If issued or renewed on or before February 28, 1996, shall, at the option of the small employer, remain in effect until the 12-month anniversary date which occurs on or before February 28, 1997.

(c) An association, multiple employer arrangement or out-of-State trust may offer and issue a non-standard health benefits plan pursuant to (b) above, if the association, multiple employer arrangement or out-of-State trust complies with the following:

1. The non-standard health benefits plan shall be offered and issued only to a small employer, as defined in N.J.S.A. 17B:27A-17 and rules promulgated pursuant to the Act, that is a member of that association, multiple employer arrangement or out-of-State trust;

2. No non-standard health benefits plan shall be issued or renewed after February 28, 1996;

3. An association, multiple employer arrangement or out-of-State trust also shall offer and, if accepted, issue standard health benefits plans to all of its small employer members; and

4. An employee's actual or expected health status shall not be used in determining whether to offer or issue a non-standard health benefits plan to any member small employer or to offer or issue coverage to employees, or their dependents, of any small employer.

(d) A carrier, association, multiple employer arrangement or out-of-State trust may offer or issue coverage under a non-standard health benefits plan to new employees of a small employer that was covered under a non-standard health benefits plan on February 28, 1994, and remain covered under such a non-standard health benefits plan, subject to the following:

1. A carrier, association, multiple employer arrangement or out-of-State trust shall not discriminate between small employers in making the offer or issue; and

2. A carrier, association, multiple employer arrangement or out-of-State trust shall not discriminate between a small employer's eligible employees in making the offer or issue.

11:21-3A.6 Cessation of issuance, renewal or continuation of non-standard health benefits plans; conversion to small employer health benefits plans

No non-standard health benefits plan may be issued or renewed in accordance with this subchapter after February 28, 1996. No non-standard health benefits plan issues, renewed or continued in accordance with this subchapter may remain in effect after the 12-month anniversary date which occurs on or before February 28, 1997. At least 60 days prior to the non-standard health benefits plan's final 12-month anniversary date, the carrier shall provide to the small employer notice that the existing policy or contract will be cancelled on its anniversary date. The carrier shall give the small employer an outline of the standard health benefits plans and the premium cost for the standard health benefits plan which is most equivalent to that policy or contract which will be cancelled. Upon request of the small employer, the small employer carrier shall provide the premium costs with respect to the other standard health plans pursuant to N.J.A.C. 11:21-7.10.

11:21-3A.7 Penalties

A carrier, association, multiple employer arrangement or out-of-State trust that violates any provision of this subchapter shall be subject to penalty and fine available under law.

SUBCHAPTER 7. PROGRAM COMPLIANCE

11:21-7.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in offering, issuing and renewing all {small employer} health plans to any small employer, the small employer's eligible employees, and the dependents of those eligible employees on or after January 1, 1994.

11:21-7.2 Definitions

All words and terms used in this subchapter shall have the meanings as set forth in the Act, N.J.A.C. 11:21-1.2 or as further defined below, unless the context clearly indicates otherwise.

. . .

"Health benefits plan" includes:

1. A standard health benefits plan;

2. From September 11, 1994 until the third anniversary date following February 28, 1994, a non-standard health benefits plan renewed, reinstated or continued in accordance with N.J.A.C. 11:21-3A.3 or 11:21-3A.4; and

3. From September 11, 1994 until the 12-month anniversary date which occurs on or before February 28, 1997, a non-standard health benefits plan issued in accordance with N.J.A.C. 11:21-3A.5.

"Non-standard health benefits plan" means only a health benefits plan that was issued to a small employer by or through a carrier, association, multiple employer arrangement or out-of-State trust prior to January 1, 1994, and which was in effect on February 28, 1994.

"Standard health benefits plan" means a health benefits plan promulgated by the SEH Board subject to the review and approval of the Commissioner, whether or not modified by rider.

...

11:21-7.3 Eligibility and issuance

(a) {A} **Except as may otherwise be provided in N.J.A.C. 11:21-3A.1 et seq. with respect to non-standard health benefits plans, a** small employer carrier shall issue a {small employee} health benefits plan to any small employer which requests it, pays the premiums therefor and meets the contribution and participation requirements, if any, of the small employer carrier. All {small employer} **standard** health benefits plan that are issued or renewed on or after January 1, 1994, **and all non-standard health benefits plans that are renewed or issued in accordance with N.J.A.C. 11:21-3A.3 or 11:21-3A.5, respectively, on or after September 11, 1994,** shall provide coverage for all eligible employees and their dependents who elect to participate regardless of their health and without exclusionary riders.

1.-2. (No change.)

3. Every small employer carrier, except small employer carriers that are HMOs, shall, as a condition of transacting business in this State, actively offer to small employers the five {small employer} **standard** health benefits plans, including all riders it writes, except as such riders may be restricted {by the Board} to specific {small employer} **standard** health benefits plans. Small employer carriers that are HMOs shall, as a condition of transacting business in this State, actively offer to small employers every {small employer} **standard** health benefits plan it writes, including all riders it writes, except as such riders may be restricted {by the Board} to specific {small employer} **standard** health benefits plans.

4.-5. (No change.)

(b) {A} **Except as otherwise provided in N.J.A.C. 11:21-3A.5 with respect to the issuance of non-standard health benefits plans, a** small employer carrier shall issue only {small employer} **standard** health benefits plans to an association, trust or multiple employer arrangement to provide coverage to member small employers or to two or more eligible employees of a member small employer.

1. No carrier shall issue a {small employer} health benefits plan to any association, trust or multiple employer arrangement which bases membership criteria of any small employer or employee of the small employer, in whole or in part, upon the health status or claims experience of the employer or employee.

2. Every small employer member of an association, trust or multiple employer arrangement shall be offered coverage under every {small employer} health benefits plan issued to the association.

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

(e) A small employer carrier providing coverage to a small employer's employees working fewer than 25 hours per week under a health benefits plan issued prior to January 1, 1994, {or renewed upon its anniversary date prior to March 1, 1994} may continue to cover {those} **part-time** employees, **including persons who become part-time employees after January 1, 1994,** when the carrier **renews or reinstates the plan in accordance with N.J.A.C. 11:21-3A.3 or 11:21-3A.4 and/or when the carrier** converts the small employer to a {small employer} **standard** health benefits plan {on the first anniversary date beginning after February 28, 1994}, **provided that;**

1. If continuing to cover **part-time** employees, the small employer carrier shall offer to continue coverage for all **part-time** employees of all such small employers **so renewing or reinstating such health benefits plan and/or** converting to a {small employer} **standard** health benefits plan, and, **in the latter case,** shall do so without regard to the {small employer} **standard** health benefits plan to which the small employer converts.

2. (No change.)

(f) A small employer carrier providing coverage to a small employer's retired employees under a health benefits plan issued prior to January 1, 1994, {or renewed upon its anniversary date prior to March 1, 1994} may continue to cover {those} retired employees, **including individuals who thereafter become retired employees,** when the carrier **renews or reinstates the plan in accordance with N.J.A.C. 11:21-3A.3 or 3A.4 and/or when the carrier** converts the small employer to a {small employer} **standard** health benefits plan {on the first anniversary date beginning after February 28, 1994}, subject to the requirements of (e)1 and 2 above with respect to such covered retired employees.

(g) A small employer carrier covering retired employees and/or employees {not} working **fewer than** 25 {or more} hours {a} **per** week of an employer that becomes a small employer subsequent to January 1, 1994 may continue to cover {such} retired employees **and/or** {noneligible} **part-time** employees, **including individuals who thereafter become retired employees or part-time employees, under a health benefits plan renewed or reinstated by the carrier in accordance with N.J.A.C. 11:21-3A.3 or 3A.4, or** a {small employer} **standard** health benefits plan issued to the small employer by the carrier, subject to the requirements of (e)1 and 2 above.

...

11:21-7.5 Restrictions on replacement of health benefits plans

(a) A small employer who purchases a **standard** health benefits plan or rider pursuant to the Act shall not be permitted to purchase a **standard** health benefits plan or rider with a greater actuarial value until the first anniversary date of the small employer's existing **standard** health benefits plan.

(b) When a small employer replaces a **standard** health benefits plan or rider with a **standard** health benefits plan or rider of greater actuarial value, the small employer shall not be permitted to change the health benefits plan or rider to one of less actuarial value until the anniversary date of the small employer's **standard** health benefits plan.

(c) A small employer who has purchased a **standard** health benefits plan or rider pursuant to the Act may purchase a **standard** health benefits plan or rider of lesser actuarial value prior to the anniversary date of the existing **standard** health benefits plan or rider, provided that the existing **standard health benefits** plan or rider was purchased at least 12 months prior to the latest anniversary date of the **standard health benefits** plan or rider.

(d) In the event that the previous **standard** health benefits plan of a small employer group was cancelled for nonpayment of premiums or fraud, a small employer carrier may:

1. Refuse to issue a **standard** health benefits plan to the small employer group for one year from the last date of coverage of the previous plan; or

2. Require the small employer group to pay up to six months of premiums in advance of the issuance of a **standard** health benefits plan.

11:21-7.6 Participation requirements

(a) A small employer carrier shall require a minimum participation under the small employer's health benefits plan of 75 percent of eligible employees except as set forth in (b) below. This participation requirement shall be applied by the small employer carrier uniformly among all {small employer} health benefits plans and all small employers. An eligible employee who is not covered under the small employer's health benefits plan because the employee is covered as a dependent under a spouse's health benefits plan, or is covered under an **indemnity plan or any** HMO plan offered by the small employer, shall be counted as covered under the small employer's health benefits plan for the purpose of satisfying participation requirements.

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

11:21-7.7 Contribution requirements

(a) A small employer carrier shall not require a minimum small employer contribution of more than 10 percent of the annual cost of the small employer's health benefits plan. This contribution requirement shall be applied by the small employer carrier uniformly among all {small employer} health benefits plans and all small employers.

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

11:21-7.8 Preexisting condition standards

(a) A {small employer} health benefits plan covering five or fewer eligible employees, as determined on the effective date of each subsequent policy anniversary, shall not deny, exclude or limit benefits, for a covered individual for losses incurred more than 180 days following the effective date of the individual's coverage due to a preexisting condition. A preexisting condition is an illness or injury which manifests itself in the six months before a covered individual's coverage under the {small employer} health benefits plan becomes effective and for which: the individual received medical care, treatment, or took prescribed drugs; or, an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the individual's coverage starts. A pregnancy which exists on the date an individual's coverage becomes effective is also a preexisting condition.

(b) A small employer carrier shall waive any time period applicable to a preexisting condition limitation period for the period of time an individual was covered under {a} **any** previous {employer's health benefits plan} **hospital and medical expense insurance policy or certificate; or health, hospital or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in the United States,** that provided benefits with respect to such {services} **condition**, provided that the qualifying previous coverage was continuous to a date not more than 90 days prior to the effective date of the new coverage. The period of continuous coverage shall not include any waiting period for the effective date of the new coverage applied under the terms of the {small employer} health benefits plan.

(c) The standards set forth in (a) above shall also apply to a late enrollee under a {small employer} health benefits plan, unless ten or more late enrollees request enrollment during any 30 day enrollment period.

11:21-7.9 Effective date of coverage

(a) A small employer carrier, prior to issuing a {small employer} health benefits plan, may require the following:

1.-2. (No change.)

3. An advance premium payment not to exceed one month's premium, except as provided in N.J.A.C. 11:21-7.5(d)2, which shall be refunded to the employer if the {small employer} health benefits plan is not issued by the small employer carrier.

(b) A small employer carrier shall provide notice to the employer within 15 working days of receipt by the small employer carrier of the information set forth in (a) above whether the small employer carrier approves or disapproves the employe's application for the {small employer} health benefits plan. If approved, the effective date of coverage under the {small employer} health benefits plan shall be no later than the first day of the month following the date of notice of such approval by the small employer carrier unless the small employer has requested a later effective date which is agreed to by the small employer carrier.

(c)-(e) (No change.)

11:21-7.12 Guaranteed renewal

(a) All {small employer} health benefits plans that are issued **or renewed** on or after January 1, 1994, must be guaranteed renewable at the option of the small employer, except for the following reasons:

1.-2. (No change.)

3. The number of employees covered under the {small employer} health benefits plan is less than the percentage of eligible employees required by participation requirements under the plan;

4.-5. (No change.)

6. The number of employees covered under the {small employer} health benefits plan is less than two;

7. A small employer ceases its membership in an association or trust of employers where the {small employer} health benefits plan was issued in connection with such membership; or

8. (No change.)

11:21-7.13 Reporting requirements

(a) Effective January 1, 1995, a small employer carrier shall file {annually,} with the Board, **annually no later than March 15,** the following information {related to small employer health benefits plans issued by the small employer carrier to small employers in New Jersey} **reported separately with respect to standard and non-standard health benefits plans**:

1. The number of small employers, covered employees and dependent units that were issued {small employer} health benefits plans in the previous calendar year, separately as to newly issued plans and renewals, and by plan design;

2. The number of {small employer} health benefits plans in force by three digit zip code **and by two digit Major Group of the Standard Industrial Classification** as of December 31 of the previous calendar year;

3. The number of {small employer} health benefits plans that were voluntarily cancelled by small employers in the previous calendar year;

4. The number of {small employer} health benefits plans that were cancelled or nonrenewed by the carrier in the previous calendar year, and the reason for such cancellation or nonrenewal; and

5. The number of {small employer health benefits plans that were issued to} small employers, **covered employees and dependents that were issued health benefits plans in the previous calendar year** that were uninsured for at least the three months prior to issue.

(b) {The information described in (a) above shall be filed with the Board no later than March 15 of each year.} **Effective on the fiscal quarter ending on September 30, 1994, a small employer carrier shall file with the Board, quarterly no later than 45 days after the end of the fiscal quarter, the following information reported separately with respect to standard and non-standard health benefits plans:**

1. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter, reported separately by plan design;

2. The total number of health benefits plans in force at the end of the quarter, and the total number of employees and dependents covered, reported separately by plan design;

3. The number of small employers, covered employees and dependents that were issued health benefits plans in the previous calendar quarter and were uninsured for at least the three months prior to issue.

(c) Annual and quarterly reports shall be filed at the address listed in N.J.A.C. 11:21-1.3.

{SUBCHAPTER 7A. CONTINUATION AND CONVERSION OF EXISTING CONTRACTS

11:21-7A.1 Purpose and scope

This subchapter sets forth the standards all carriers must meet in renewing or continuing any policy or contract delivered or issued for delivery to a small employer prior to January 1, 1994.

11:21-7A.2 Conversion

(a) A policy or contract covering one or more employees or a small employer issued by a carrier prior to January 1, 1994, shall remain in effect at the small employer's option until the first anniversary date after February 28, 1994, of that policy or contract, unless the carrier institutes a withdrawal in accordance with N.J.S.A. 17B:27A-23(e) and rules promulgated thereunder by the Commissioner.

(b) A carrier shall notify each small employer at least 60 days prior to the policy or contract anniversary date that the existing policy or contract will be cancelled on its anniversary date. If the carrier is a small employer carrier, it shall give the small employer

an outline of the small employer health benefits plans and the premium cost for the small employer health benefits plan which is most equivalent to that policy or contract which will be cancelled. Upon request of the small employer, the small employer carrier shall provide an outline and premium costs with respect to any other small employer health benefits plans offered by the small employer carrier.

11:21-7A.3 Continuation

The requirements of N.J.S.A. 17B:27A-27 shall apply, effective January 1, 1994, to every policy or contract issued to a small employer which is continued in accordance with N.J.A.C. 11:21-7A.2 above.]

EXHIBIT N

[Carrier]

APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

Please print or type

Policy number: ([Carrier] Use Only)

☐ New Policy ☐ Change in Policy

Requested Effective Date: _____

SECTION I: POLICYHOLDER INFORMATION

1. Policyholder (full legal name of company): _____
2. Tax Identification Number: _____
3. Main Address: _____
   Street *City* *State* *Zip*

   Mailing Address: _____
   Street *City* *State* *Zip*

   Telephone: ( ) _____ Fascimile: ( ) _____
4. Name of Correspondent: _____ Title: _____
5. Type of organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other (explain): _____
6. Nature of business (specify): _____ SIC Code: _____
7. Number of eligible employees in your company: _____
   [*(Eligible employees are those who work at least* **25** *hours per week)*]

   Refer to the New Jersey Small Employer Certification for the definition of an eligible employee
8. Number of eligible employees to be insured: _____
9. Class or classes to be excluded: _____
10. Insurance Requested For: ☐ Employees Only ☐ Employees and Dependents
11. Are you subject to the requirements of COBRA? ☐ Yes ☐ No
12. Waiting period before employees become insured: (may not exceed 6 months)
    Present employees: _____ New Employees _____
13. What percentage of the premium will the employer pay? _____
14. Deposit $ _____

Premium Paid: ☐ Monthly ☐ Quarterly [☐ Automatic checking withdrawal]
Premium will be due as of the effective date. The premium for the first month of coverage **must** be attached.

Affiliates, subsidiaries or branches (Must be included for purposes of participation)

Legal Name & Location	No. eligible ees in this company	No. eligible ees to be insured	[Type of organization]	[Nature of business]

SECTION II: SPECIFICATIONS FOR COVERAGE

[HEALTH BENEFITS

☐ Wraparound (Hospital Base Plan _____ days)

Plan: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO

Deductible (Options for plans B, C and D only): ☐ $250 ☐ $500 ☐ $1,000

Co-Payment (Options for HMO Plans Only) ☐ $5 ☐ $10 ☐ $15 ☐ $20

Managed Care Delivery System: ☐ PPO ☐ POS ☐ None

PRESCRIPTION DRUG BENEFITS

Program Type: ☐ Card ☐ Mail Order ☐ Card/Mail Order

MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Co-Payment Option ☐ $5 ☐ $10 ☐ $15 ☐ $20]

SECTION III: ALL QUESTIONS MUST BE ANSWERED

1a. Is there any insurance plan:

- now inforce and to be continued? ☐ Yes ☐ No
- currently being applied for? ☐ Yes ☐ No

If "Yes" give a description of the plan and name of insurance carrier(s) _____

b. Name of present or prior group carrier _____

Effective date of prior coverage: _____ Cancellation/termination date: _____

Is the coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

If "Yes", give reason _____

Plan being replaced: ☐ A ☐ B ☐ C ☐ D ☐ E ☐ HMO ☐ Other _____

c. Has your firm been uninsured for 3 or more months prior to application? ☐ Yes ☐ No

4. What forms of insurance are now or were inforce? ☐ Health Benefits ☐ Prescription Drugs (Attach copies of Booklet/Certificate and most recent Billing Statement)

5. Are extended benefits provided in case of termination of health benefits? ☐ Yes ☐ No

6. To the best of your knowledge are there any current or former employees or their eligible dependents whose health insurance is being continued? ☐ Yes ☐ No

Please provide the following information for each current/former employee or dependent on health continuations.

Name of Employee/Dependent	Date of Birth	Type of Continuation State/Federal/ Extended Benefits	Reason for Termination Disability/Other	Continuation Dates Start	End

If additional space is needed, attach a separate sheet, signed and dated.

7. To the best of your knowledge

a. Are any employees or dependents presently incapacitated? ☐ Yes ☐ No
b. Are any dependent children incapable of self-support due to a physical or mental disability? ☐ Yes ☐ No

Additional space to explain if items 1, 2 or 3 were answered "Yes". Refer to the question number, and give details including names, where appropriate.

SECTION IV: AGENT/PRODUCER INFORMATION

[To be supplied by Carrier]

SECTION V: SIGNATURE

[It is understood that no individual shall become insured while not actively at work on a full-time basis, and only full-time employees are eligible. A full-time employee is one who regularly works at least 25 hours per week at his employer's place of business.] It is further understood that no agent has power on behalf of [Carrier] to make or modify any request or application for insurance or to bind [Carrier] by making any promise or representation or by giving or receiving any information.

It is further understood that no insurance will be effective unless and until the application is accepted in writing by [Carrier]. No contract of insurance is to be implied in any way on the basis of the completion and/or submission of this application.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

Dated at _____ on _____

Print name of Officer, Partner or Proprietor

Signature of Officer, Partner or Proprietor

Witness to Signature

Note: If there are any modifications to the statements and answers given in this application (i.e. crossed out, whited-out, erased information), the applicant must attest to the modifications) by giving a complete signature in the margin near the modification.

EXPLANATION OF BRACKETS AND TEXT
APPLICATION FOR A SMALL EMPLOYER HEALTH BENEFITS POLICY

1. The terms Policyholder and Policy may be replaced with Contractholder or Planholder and Contract or Plan, as appropriate.

2. The terms insurance and insured may be replaced with coverage and covered, as appropriate.

3. The reference to Automatic Checking Withdrawal may be deleted if Carrier does not offer such options.

4. The text of the Health Benefits section may vary to accommodate the options a Carrier will offer. For example, if a Carrier does not offer HMO plans, such text may be deleted.

5. Agent/Producer Information may be consistent with a Carrier's usual procedures.

6. If benefits are to be issued through a Multiple Employer Trust, a Carrier may include text which specifies that the employer is requesting participation in a Trust.

7. If a Carrier provided coverage to a small employer's employees working fewer than 25 hours per week and/or retirees under a health benefits plan issued prior to January 1, 1994, and such Carrier elects to continue to cover part-time employees and/or retirees after January 1, 1994, under the terms and conditions outlined in N.J.A.C. 11:21.7.3 (e) and (f), the text of the first 2 sentences of the Signature section may be adjusted to reflect the expanded eligibility.

EXHIBIT O

NEW JERSEY SMALL EMPLOYER CERTIFICATION

For a policy of Group Health Benefits Insurance

Employer Name _____ Group Policy No. _____

Address _____ Street _____ City _____ State _____ Zip _____

EMPLOYEE CENSUS INFORMATION

Please include the following persons in the following list:

a. employees, owners, partners, officers, and independent contractors who are actively working for the employer on a regular basis, whether or not they are eligible to be covered under the policy.

b. employees, owners, partners, officers, and independent contractors who are not working, but who are currently covered under the employer's health benefits plan for reasons such as continuation of coverage or total disability.

Please use the following letters to indicate Status:

F: Full-time employee who works 25 or more hours per week
P: Part-time employee who works less than 25 hours per week
T: Temporary employee
I: Independent Contractor
D: Totally Disabled employee
C: Continuee under state or federal law
U: Employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement

Name	**Job Title**	Date of Employment	Hours worked per week	Status	**Work Location (State)**
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					

If additional space is needed, attach a separate sheet.

{SEH-SEC-11/93-2} **SEH-SEC-6/94-1**

CERTIFICATION AS A SMALL EMPLOYER IN THE STATE OF NEW JERSEY IN ACCORDANCE WITH NEW JERSEY CH. 162

Group Health Benefits Policy Participation (All Questions Must Be Answered)

An Eligible Employee is one who works on a full-time basis with a normal work week of 25 or more hours. An employee who works less than 25 hours per week {or}, on a temporary or substitute basis, or an employee participating in an employee welfare arrangement established pursuant to a collective bargaining agreement is not an eligible employee.

Total # Eligible Employees _____

Total # Eligible Employees applying for health benefits coverage _____

Total # Eligible Employees waiving health benefits coverage under this policy with coverage elsewhere _____

Total # Eligible Employees waiving health benefits coverage under this policy without coverage elsewhere _____

Total # Eligible Employees with Eligible Dependents _____

Total # Eligible Employees applying for Dependent health benefits coverage _____

Total # Eligible Employees waiving Dependent health benefits coverage under this policy with coverage elsewhere _____

Total # Eligible Employees waiving Dependent health benefits coverage under this policy without coverage elsewhere _____

CERTIFICATION

(Please sign and date appropriate section indicating whether or not you meet the definition of a small employer)

A Small Employer is any person, firm, corporation, partnership or association actively engaged in business who during at least fifty percent of its working days in the preceding CALENDAR YEAR/QUARTER, employed NO MORE THAN FORTY-NINE eligible employees and NO LESS THAN TWO eligible employees, the majority of whom were employed in the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer.

I certify that I qualify as a Small Employer in the State of New Jersey.

I certify that the information provided to [Carrier] is true and complete. I understand that if the above information is not complete or is not provided to [Carrier] in a timely manner, then health benefits coverage does not have to be offered or continued. I further understand that incomplete or untrue information may void health benefits coverage.

Any person who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information, may be subject to criminal and civil penalties.

_____

Signature of Officer, Partner, or Owner Title Date

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness Date

_____

I certify that I am not a Small Employer in the State of New Jersey, as defined above.

_____

Signature of Officer, Partner, or Owner Title Date

_____

Print Name of Officer, Partner, or Owner

_____

Signature of Witness Date

{SEH-APP-6/93-4} **SEH-SEC-6/94-2**

EXHIBIT Q

[CARRIER]

SMALL GROUP EMPLOYER BENEFITS ENROLLMENT FORM [AND (HEALTH) PRE-EXISTING CONDITIONS STATEMENT]

[Policyholder] (full legal name of company): _____ [Policy] No. _____

[Policyholder] Address: _____
Street City State Zip Code

SECTION I: EMPLOYEE INFORMATION

Name: _____ [Telephone: _____]
Last First Middle Initial

[Home Address:] _____
Street City State Zip Code

Occupation: _____ Title: _____

Date of Employment: _____ Hours worked per week: _____

Are you actively at work? ☐ Yes ☐ No If "No", explain _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

[Reason for Enrollment (Please check appropriate boxes)

☐ I am an employee of an organization which is applying for coverage.
☐ I am now eligible for coverage.
☐ I had previous coverage during the past 90 days.
Name of previous carrier _____ Plan # _____
How long were you covered? _____
☐ I previously refused/waived coverage
☐ I am applying for coverage during my organization's HMO open enrollment period. Open enrollment date: _____
☐ I am continuing coverage under state or federal law.
☐ I am adding [deleting] dependent(s)
☐ other (specify) _____]

SECTION II: COVERAGE INFORMATION

1. Persons to be covered: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

2. Please provide all information for each person to be covered.

Full Name Last, First, MI	Sex	Social Security #	[Place of Birth]	Birthdate	[Height]	[Weight]
Employee						
Spouse						
Child						
Child						
Child						
Child						

3. Indicate whether you and/or your spouse, if any, are enrolled under Part A and/or Part B of Medicare

	Plan A	Plan B	Medicare ID. #
Employee	☐ Yes ☐ No	☐ Yes ☐ No	_____
Spouse	☐ Yes ☐ No	☐ Yes ☐ No	_____

4: Which coverage have you selected to be primary in the event expenses are incurred as a result of an automobile related injury?
☐ Auto ☐ Medical

[5. Name(s) of Primary Care Physician(s) _____]

SEH-ENROLL-{8/93}**6/94-1**

SECTION IV: DECLARATION AND AUTHORIZATION

I hereby apply for the group coverage for which I am or may become entitled. I authorize deductions from my pay for my share of the cost, if any.

I represent to the best of my knowledge and belief, that the statements and answers given above are true and complete. I understand that the information, [other than the {health} Pre-Existing Conditions Statement information,] shall form the basis upon which I may be included for coverage under the group plan.

I understand that:

a. the coverage applied for will not take effect unless:

- the first premium has been paid to [Carrier]; and
- I am actively at work for full pay on a full time basis on the date coverage is to take effect.

b. no person, except an officer of [Carrier], has authority to: determine whether any certificate shall be issued on the basis of this Enrollment Form and {Health} Pre-Existing Conditions Statement; waive or modify any of the provisions of the Enrollment Form [and {Health} Pre-Existing Conditions Statement] or any of [Carrier's] requirements; to bind [Carrier] by any statement or promise pertaining to any certificate signed or to be issued on the basis of this Enrollment [and {Health} Pre-Existing Conditions Statement;] or accept any information or representation not contained in the written Enrollment Form [and {Health} Pre-Existing Conditions Statement.]

c. the Employer is hereby designated my representative for the purpose of receiving {premiums} contributions and remitting them to [Carrier].

[d. I understand that [Carrier] does not pay benefits for charges for Pre-Existing Conditions until a person covered under the Policy has been continuously covered under the Policy for 180 days. I understand that the following are Pre-Existing Conditions:

- an illness or injury which manifests itself during the 6 months prior to the date a person's coverage takes effect and for which: a. the person sees a Practitioner, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the 6 months before coverage takes effect; or b. an ordinarily prudent person would have sought medical advice, care, or treatment in the 6 months before coverage starts

- a pregnancy which exists on the date a person's coverage takes effect.]

Note: Any person who knowlingly files a statement of claim, application for insurance, enrollment form [or {health} Pre-Existing Conditions statement], containing any false or misleading information may be subject to criminal and civil penalties.

AUTHORIZATION

1. I authorize the sources stated below to give to [Carrier], or any consumer reporting agency acting on its behalf, information about me and my minor children, if applying for insurance. Such information will pertain to employment; other insurance coverage; and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any insurer; {the Medical Information Bureau;} any consumer reporting agency; any employer.
2. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which [Carrier] has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier.
3. I know that I have the right to receive a copy of this authorization if I request one.
4. I agree that a photocopy of this authorization is as valid as the original.

(Date Signed)	(Signature of Employee)
[(Date Signed)	(Signature of Spouse, if {giving a statement of health} providing information on the pre-existing conditions statement
(Date Signed)	(Signature of Child Who is age 18 or older, if {giving a statement of health} providing information on the pre-existing conditions statement]

SEH-ENROLL-6/94-3

SECTION IV: DECLARATION AND AUTHORIZATION (Continued)

- - - -

EXHIBIT Q

EXPLANATION OF BRACKETS
SMALL EMPLOYER HEALTH BENEFITS

Enrollment Form, and [Health] **Pre-Existing Conditions** Statement and Waiver Form

1. The terms Policyholder and Policy may be replaced with Contractholder or Planholder and Contractor Plan, as appropriate.

2. If Carrier does not need to capture the telephone number, such item may be deleted.

3. Home Address may be replaced with Primary Residence Address.

4. If the carrier uses administrative forms for some of the actions identified in the Reasons for Enrollment section, all or parts of the text may be deleted.

5. Additional lines for Child Data may be included.

6. The space for Names of Primary Care Physicians may be deleted if Carrier does not offer plans which rely upon Primary Care Physicians. If the item is included, it may be expanded to request the name of the Primary Care Physician for each person to be covered.

7. If the Carrier does not elect to use health information [for the purpose of rating or] to assist with establishing the existence of a pre-existing condition, the [health] **pre-existing conditions statement** should not be included.

[8. If the Carrier does not use MIB information, the reference to MIB in the Authorization may be deleted. The Disclosure may be also deleted.]

[9] 8. Item d. of the Declaration and Authorization may always be deleted or Carrier may include the text only when the Pre-Existing Conditions provisions may be applicable.

[10] 9. Carrier may elect to produce the Enrollment Form, [Health] Pre-Existing Conditions Statement, if used, and Waiver Form as a single form.

EXHIBIT R

. . .

[6. {HEALTH} PRE-EXISTING CONDITIONS STATEMENT

Note: This information {will not be used for any purpose prohibited by law.} may only be used to determine if a condition is a Pre-Existing Condition. You must not be denied coverage under the health benefits plan on the basis of accurate responses to the following questions, but benefits for treatment and services of Pre-Existing Conditions may be limited for up to 180 days. This form and restriction of benefits applies only to employers with 2-5 employees. Answer each question by checking the "Yes" or "No" box as it applies. If "Yes" is checked, provide details below. Have you or any dependent to be covered {ever} in the 6 months prior to the date of your coverage under the group contract will take effect had or been diagnosed as having:

		Yes	No
1.	a. Alcoholism, Drug Abuse	☐	☐
	b. Arthritis	☐	☐
	c. Back or Neck Disorder, Injury or Pain	☐	☐
	d. Blood Disorder	☐	☐
	e. Cancer or Tumors	☐	☐
	f. Diabetes	☐	☐
	g. Gastro or Intestinal Disorder	☐	☐
	h. Heart Disorder or Condition or Chest Pain	☐	☐
	i. High Blood Pressure	☐	☐
	j. Kidney or Liver Disorder	☐	☐
	k. Lung or Respiratory Disorder	☐	☐
	l. Mental or Nervous Disorder	☐	☐
	m. Paralysis, Stroke or Epilepsy	☐	☐
	n. Does Pregnancy Exist	☐	☐
	Expected Due Date:	☐	☐

{2. Have you or any dependent to be covered been diagnosed by a member of the medical profession as have AIDS or HIV+ (positive)?} ☐ ☐

{3.} 2. In the {past five (5) years} six months prior to the date your coverage under the group contract will take effect, have you or any dependent to be covered:

	Yes	No
a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	☐	☐
b. been advised to have treatment or surgery or testing that has not been done?	☐	☐
c. been admitted to a hospital or other health care facility as an inpatient?	☐	☐
d. taken prescribed medication(s)?	☐	☐
{e. used tobacco products?}		

{4. Please indicate your height.

5. Please indicate your weight. _____ lbs. }

Please give details for any "Yes" answers to any parts of questions 1, 2 {or 3} Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and Letter	Name of Person	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospitals, Practitioners

. . .

EXHIBIT S

[SECTION III: [HEALTH] PRE-EXISTING CONDITIONS STATEMENT

Note: This information {will **not** be used for any purpose prohibited by law} may only be used to determine if a condition is a Pre-Existing Condition. You may not be denied coverage under the health benefits plan on the basis of accurate responses to the following questions, but benefits for treatment and services of Pre-Existing Conditions may be limited for up to 180 days. This form and restriction of benefits apply only to employers with 2-5 employees.

Answer each question by checking the "Yes" or "No" box, as it applies. If "Yes" is checked, provide details below.

[In the six (6) months prior to the date of your coverage under the group policy will take effect, have you or any dependent to be covered {ever} had or been diagnosed as having:

	Yes	No
1. a. Alcoholism, Drug Abuse	☐	☐
b. Arthritis	☐	☐
c. Back or Neck Disorder, Injury or Pain	☐	☐
d. Blood Disorder	☐	☐
e. Cancer or Tumors	☐	☐
f. Diabetes	☐	☐
g. Gastro or Intestinal Disorder	☐	☐
h. Heart Disorder or Condition or Chest Pains	☐	☐
i. High Blood Pressure	☐	☐
j. Kidney or Liver Disorder	☐	☐
k. Lung or Respiratory Disorder	☐	☐
l. Mental or Nervous Disorder	☐	☐
m. Paralysis, Stroke or Epilepsy	☐	☐
n. Does Pregnancy Exist	☐	☐
Expected Due Date: _____]		

{2. Have you or any dependent to be covered been diagnosed by a member of the medical profession as having AIDS or HIV+ (positive)? ☐ ☐}

{3.} [2.] In the {past five (5) years} six (6) months prior to the date your coverage under the group policy will take effect, have you or any dependent to be covered:

a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	☐	☐
b. been advised to have treatment or surgery or testing that has not been done?	☐	☐
c. been admitted to a hospital or other health care facility as an inpatient?	☐	☐
d. taken prescribed medication(s)?	☐	☐
{e. used tobacco products?	☐	☐}

Please give details for any "Yes" answers to any parts of questions 1 or 2. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question # and Letter	*Name of Person*	*Condition*	*Duration of Symptoms, Treatment Degree of Recovery*	*Date*	*Name and Address of Hospitals, Practitioners*

SEH-ENROLL-(8/93)**6/94-2**]

EXHIBIT T

[CARRIER]

SMALL EMPLOYER HEALTH BENEFITS WAIVER OF COVERAGE

Group Policy No. _____

Policyholder Name: _____

Employee Name: _____ Social Security #_____
Last First MI

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Date of Employment: _____ Date of Birth _____

I was given the opportunity to enroll in this plan of group health benefits offered by my employer and insured by [Carrier]. I *refuse* the following:

☐ Employee, Spouse and Child(ren) coverage

☐ Spouse coverage

☐ Child(ren) coverage

Reason for Refusal (Please check all appropriate boxes.)

☐ other group coverage sponsored by my employer

☐ other group coverage sponsored by my spouse's employer

☐ other group coverage sponsored by another organization

☐ other reasons (please explain) _____

Please provide name of carrier and policy number: _____

I understand that if I later wish to enroll for any of the coverage(s) refused, I will be required to submit an Enrollment Form [and {Health} **Pre-Existing Conditions** Statement], and coverage may be subject to a preexisting conditions exclusion.

_____ _____
Signature of Employee Date

_____ _____
Signature of Witness Date

SEH-WAIV-{8/93}**6/94**

RULE ADOPTIONS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Special Hearing Rules
Family Development Hearings
Adopted Amendments: N.J.A.C. 1:10-1.1
Adopted New Rules: N.J.A.C. 1:10-14.2 and 14.3

Proposed: May 2, 1994 at 26 N.J.R. 1744(b).
Adopted: July 13, 1994 by Jaynee LaVecchia, Director, Office of Administrative Law.
Filed: July 13, 1994 as R.1994 d.417, **without change.**

Authority: N.J.S.A. 52:14F-5(e), (f) and (g).

Effective Date: August 15, 1994.
Expiration Date: April 21, 1997.

Summary of Public Comments and Agency Response:
No comments received.

Full text of the adoption follows:

1:10-1.1 Applicability

(a) The rules in this chapter shall apply to matters transmitted to the Office of Administrative Law by the Division of Family Development (DFD) where an applicant or recipient disputes the proposed action on eligibility or benefits entitlement by a county welfare agency (CWA) or a local decision or inaction by a municipal welfare department (MWD). These rules also apply to food stamp intentional program violations. Any aspect of the hearing not covered by these special hearing rules shall be governed by the Uniform Administrative Procedure Rules (U.A.P.R.) contained in N.J.A.C. 1:1. To the extent that these rules are inconsistent with the U.A.P.R., these rules shall apply.

(b) These rules are established in implementation of Federal law, 7 C.F.R. 273.16; 45 C.F.R. §205.10; 7 C.F.R. §273.15. In any case where these rules can be construed as conflicting with Federal requirements, the Federal requirements shall apply. Since these rules are established in implementation of Federal law, they may not be relaxed except as specifically provided pursuant to Federal law.

1:10-14.2 Intentional program violation hearings

At an intentional program violation hearing, the charged applicant/recipient has a right to remain silent and may refuse to answer questions. 7 C.F.R. 273.16(e)(2)(iii); 45 C.F.R. 235.113(b)(3)(ii)(K).

1:10-14.3 Independent medical assessment

For good cause, the administrative law judge may order an independent medical assessment or professional evaluation when the hearing involves medical issues. Such medical assessment shall be obtained at CWA or MWD expense. 7 C.F.R. 273.15(m)(2)(v); 7 C.F.R. 273.16(e)(2)(ii); 45 C.F.R. 205.10(a)(iii)(10); 45 C.F.R. 235.113(b)(6).

INSURANCE

(b)

DIVISION OF PROPERTY AND CASUALTY

Reporting Financial Disclosure and Excess Profits
Adopted Amendment: N.J.A.C. 11:3-20.6

Proposed: May 16, 1994 at 26 N.J.R. 1938(b).
Adopted: July 25, 1994 by Andrew J. Karpinski, Commissioner, Department of Insurance.
Filed: July 25, 1994 as R.1994 d.425, **without change.**

Authority: N.J.S.A. 17:1C-6(e), 17:1-8.1 and 17:29A-5.6 et seq.

Effective Date: August 15, 1994.
Expiration Date: January 4, 1996.

Summary of Public Comments and Agency Responses:

The Department received five timely written comments from insurers as follows:

1. Allstate Insurance Company;
2. Selective Insurance Group, Inc.;
3. United Services Automobile Association and USAA Casualty Insurance Company;
4. New Jersey Manufacturers Insurance Companies; and
5. State Farm Indemnity Company.

COMMENT: All of the commenters supported the proposed amendment to N.J.A.C. 11:3-20.6, which provides that for purposes of evaluating the excess profits due July 1, 1994 and July 1, 1995, the excess profits computation shall be performed solely on the insurance holding company system's combined profits report.

In addition, virtually all of the commenters stated that the proposed amendment should be made "permanent" rather than limited only to the 1994 and 1995 profits report. In other words, the commenters stated that the excess profit calculation should be performed solely on the insurance holding company system's combined report. The commenters generally believe that this change is necessary since certain companies use affiliated companies to manage the differing risks in the automobile insurance market. Moreover, the commenters generally believe that the change would accurately recognize that using affiliates is "essentially the same as using multiple rating tiers or classifications within a single company."

One commenter specifically stated that the continuing effects of the requirement that automobile insurers insure all eligible persons are distortions in individual company's results similar to those resulting from depopulation that the Department noted in the Summary to the proposal. The commenters asserted that since the basis for the rule will continue to exist after 1995 (that is, material losses in one member of a holding company and less severe losses in another), the two-year limitation on the application of the rule should be eliminated.

Another commenter specifically suggested that the proposed amendment be extended to include the excess profits report due July 1, 1996 because the transfer of business between its affiliates took place between October 1992 and March 1994, with virtually all transfers taking place in 1993. The commenter stated that because the excess profits report due in 1996 will include results in 1993, individual company results may be distorted. In addition, the commenter stated that because, in many cases, the rates charged by different affiliates were either identical or substantially similar, it would be appropriate to determine excess profits based solely on the combined report. The commenter further believes that computation based on each affiliate would be appropriate only where each affiliate sets its own rates based on its own experience independently of other affiliates. The commenter does not believe that affiliates in any insurer group currently set rates based on individual experience.

RESPONSE: The Department notes the commenters' support for the proposed amendment. With respect to the extension of the two-year limitation provided for in the proposed amendment, the Department notes that such a change would be substantive and could not be made upon adoption, that is, without notice and opportunity to comment. In order to implement the commenters' suggestion would require repeal or modification of N.J.A.C. 11:3-20.6(c), as well as changes to other provisions in the rules.

The Department will, however, monitor the effect of this amendment and evaluate conditions existing in 1995 with respect to the filing of future excess profits reports, and will determine whether any amendments to the existing rules are necessary and appropriate.

COMMENT: Two commenters recommended that the Department evaluate other provisions of the excess profits rules, N.J.A.C. 11:3-20 and 11:3-20A, to address those provisions which the commenters believe may have the effect of "ignoring" or distorting actual financial results of insurers.

RESPONSE: As one of the commenters noted, such comments are outside the scope of this proposal. Moreover, no specific comments or suggestions were provided with respect to the existing excess profits rules.

However, the Department would consider any comments or suggestions that may be submitted by interested parties with respect to the current excess profits requirements for possible future amendment.

Full text of the adoption follows:

11:3-20.6 Reporting requirements for insurance holding companies
(a)-(c) (No change.)
(d) Notwithstanding any provision of this section to the contrary, for purposes of evaluating the Excess Profits Reports due July 1, 1994 and July 1, 1995, the excess profits computation shall be performed solely on the insurance holding company system's combined profits report.

(a)

DIVISION OF THE REAL ESTATE COMMISSION

Notice of Administrative Correction Educational Requirements for Salespersons and Brokers in Making Application for Licensure Examinations

N.J.A.C. 11:5-1.27

Take notice that the New Jersey Real Estate Commission has discovered an error in the text of N.J.A.C. 11:5-1.27(g)1xvi, in that that subparagraph's cross-reference to subparagraphs "(a)1xvi(1) through (6) below" needs to instead refer to "(g)1xvi(1) through (6) below." Those subparagraphs in subsection (g) clearly contain the appropriate subject matter, and the erroneously cited codification in subsection (a) does not exist. This notice is published pursuant to N.J.A.C. 1:30-2.7.

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

11:5-1.27 Educational requirements for salespersons and brokers in making application for licensure examination
(a)-(f) (No change.)
(g) The 150 hours of prelicensure education required of candidates for licensure as a broker or broker-salesperson by N.J.S.A. 45:15-10 shall be acquired as provided in this subsection. A 90 hour general broker's prelicensure course shall first be completed in accordance with the following syllabus and directives. Thereafter, two 30 hour broker courses as described in (g)5, 6 and 7 below shall be completed. All three courses, totalling 150 hours of instruction, must be successfully completed within a period of two years. Where the three courses are not so completed, a candidate must again successfully complete any previously taken course and all courses not previously taken within the two year time frame, and again fulfill the experience requirement established at N.J.S.A. 45:15-9 and N.J.A.C. 11:5-1.3 in order to qualify to challenge the broker license examination.
1. The 90 hour general broker's prelicensure course may be taught in blocks or modules of material. The maximum number of modules into which the course may be divided is 23, with their content corresponding to the 23 subject matter areas identified in the syllabus below. Schools offering courses in modules may include more than one subject matter area in a given module. No student may commence a course which is offered in modules on a date other than the starting date of any module. No student shall be given credit for the successful completion of a 90 hour general broker's prelicensure course unless and until they have received instruction in all of the subject matter areas identified below for approximately the number of hours indicated, and passed a comprehensive final examination. The 90 hour general broker's prelicensure course shall be conducted in accordance with the following syllabus and directives. Substantive instruction shall be provided on the following topics for approximately the number of hours indicated:
xvi. Business and management practices (total of six hours for [(a)](g)1xvi(1) through (6) below), including:
(1)-(6) (No change.)
xvii.-xxiii. (No change.)
2.-7. (No change.)
(h)-(j) (No change.)

(b)

SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program Enrollment; Permissible Rate Classification Factors; Optional Benefit Riders

Adopted New Rule: N.J.A.C. 11:21-7.15
Adopted Amendments: N.J.A.C. 11:21-3.2(d), 4.1(c), and Exhibits A through F

Proposed: June 1, 1994 in accordance with N.J.S.A. 17B:27A-51, at 26 N.J.R. 2843(a).
Adopted: July 13, 1994 by the New Jersey Small Employer Health Benefits Program Board, Maureen Lopes, Chair.
Filed: July 15, 1994 as R.1994 d.418, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).
Authority: N.J.S.A. 17B:27A-17 et seq., as amended by N.J.S.A. 17B:27A-51 and P.L. 1994, c.11.
Effective Date: July 15, 1994.
Operative Date of N.J.A.C. 11:21-7.15: September 11, 1994.
Expiration Date: October 15, 1998.

This new rule was proposed and is being adopted pursuant to the procedures of N.J.S.A. 17B:27A-17 et seq., as therein authorized. Accordingly, notice of the proposal was published in three newspapers of general circulation in New Jersey, and mailed to all known interested parties when submitted to the Office of Administrative Law ("OAL") for publication in the New Jersey Register. Upon expiration of a 20-day public comment period following the publication of notice of the proposal, the proposed rules may be adopted immediately. The Board must respond to comments received within a reasonable period following the adoption of the proposal and submit the Board's responses to the OAL for publication in the New Jersey Register. The Board's responses to public comments received are contained herein.

Comments were received from the following:
Blue Cross and Blue Shield of New Jersey
The Prudential Insurance Company of America

COMMENT: One commenter took issue with a statement contained in the "Summary" section of the proposal, not in the rule itself, that all health benefits plans issued or renewed after September 1, 1996 would have to be community rated. The commenter suggested that the correct date for the requirement of community rating should be January 1, 1997.

RESPONSE: The Board agrees that September 1, 1996 is not correct. The law provides that health benefits plans issued to small employers must be community rated beginning on the third 12-month anniversary date of any policy or contract issued in 1994. Therefore, all health benefits plans will have to be community rated beginning on the issuance or anniversary date occurring during calendar year 1997. Since the date after which community rating is required is not contained in the rule, and is statutory, no change in the rule is required.

COMMENT: One commenter pointed out that the proposed amendment to N.J.A.C. 11:21-6.3(c) should not have contained the word "or" before the term "pre-existing condition" and that "or" should be deleted from the adoption.

RESPONSE: The Board agrees that the word "or" should not appear before the term "pre-existing condition." Its inclusion was a technical drafting error, and its deletion is a technical change to the final rule not requiring reproposal.

COMMENT: One commenter asked whether N.J.A.C. 11:21-7.15 provides for a rate differential on the basis of whether Medicare is considered primary or secondary insurance.

RESPONSE: The rule only addresses the three rating factors provided in P.L. 1994, c.11: age, gender and geography; and, as provided in P.L. 1992, c.162, N.J.S.A. 17B:27A-25(e), family structure.

Summary of Agency-Initiated Changes:

1. N.J.A.C. 11:21-3.2(d)4iv has been changed by adding a requirement that the certification therein referenced contain a statement that the carrier has made a rate filing with the Commissioner pursuant to N.J.A.C. 11:21-9. This additional language is intended to ensure that carriers do not fail to file rates with the Commissioner before issuing a rider. This addition to the certification does not impose any substantive requirement on carriers seeking to issue riders; rather, the additional statement is a cross reference to the Commissioner's rate filing rule. The change is not so substantive as to require reproposal or opportunity for public comment.

2. N.J.A.C. 11:21-3.2(d)5 has been changed by deleting a comma after the word "subsection" in the first sentence. The change is technical, not substantive, and does not require reproposal or opportunity for public comment.

3. N.J.A.C. 11:21-6.3(c)1 and 7.15(a) have been changed to reflect that the various reforms affecting non-standard health benefits plans take effect on and after September 11, 1994, which is the sixtieth day after the Board's adoption of N.J.A.C. 11:21-7.15, the date provided in P.L. 1994, c.11, section 3(j). The change is technical, not substantive, and does not require reproposal or opportunity for public comment.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in cursive brackets with asterisks *{thus}*):

11:21-3.2 Optional benefit riders

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

(d) In addition to the optional benefit riders listed in (c) above, members may offer riders that revise in any way the coverage offered by Plans A, B, C, D, E and HMO, subject to the provisions set forth in (d)1 through 5 below.

1. Before a member may sell a rider or amendment thereof that decreases any benefits or decreases the actuarial values of Plans A, B, C, D, E or HMO, the member shall file the rider or amendment thereof for informational purposes with the Board, and for approval by the Commissioner. No rider filed with the Commissioner may be sold until approved by the Commissioner and the carrier has either received appropriate notice from the Board or the filing is deemed to be in substantial compliance under (d)5 below.

2. Before a member may sell a rider or amendment thereof that increases any benefits or increases the actuarial value of Plans A, B, C, D, E or HMO, the member shall file the rider or amendment thereof with the Board for informational purposes.

3. In addition to (d)1 and 2 above, any benefit rider or amendments thereof shall be subject to the provisions of Sections 2, 3(b), 6, 7, 8, 9 and 11 of P.L. 1992, c.162.

4. A member making an informational filing to the Board pursuant to (d)1 or 2 above shall:

i. Submit the filing and any related materials to the Board in triplicate at the address specified at N.J.A.C. 11:21-1.3;

ii. Specify whether the rider or amendment thereof is to be used in connection with Plan A, B, C, D, E or HMO and provide clear and conspicuous notice of such on the forms submitted for each rider;

iii. Submit, in triplicate, a copy of each health benefits plan to be used in connection with a rider or amendment thereof clearly marked to show how the rider or amendment thereof changes the language of Plan A, B, C, D, E, or HMO; and

iv. Submit a certification signed by a duly authorized officer of the member that states clearly:

(1) Whether the rider or amendment thereof increases or decreases the benefits or actuarial value of Plan A, B, C, D, E, or HMO and include a detailed actuarial memorandum that supports the statement of actuarial value;

(2) That the filing is complete and in accordance with all the requirements of this subsection*{; and}*

(3) That the member will offer the rider or amendment thereof to any small employer seeking to purchase the health benefits plan it modifies***; and**

(4) That a rate filing has been made with the Commissioner pursuant to N.J.A.C. 11:21-9*.

5. The Board shall notify a member in writing of its determination of whether an informational filing is complete and in substantial compliance with this subsection*{,}* within 30 days of the member's submission of a rider or amendment thereof. If the Board does not notify a member of its determination with respect to an informational filing within 30 days of the date of submission thereof, the informational filing shall be deemed complete.

i. If an informational filing is incomplete, but in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing.

ii. If an informational filing is incomplete and not in substantial compliance with the requirements of this subchapter, the notification shall provide the reasons the filing is incomplete and what additional information needs to be submitted by the member. The member shall provide the Board with the information required to complete the filing. Upon receipt of notice from the Board that a filing is incomplete and not in substantial compliance with the requirements of this subchapter, the member shall not sell the rider or amendment thereof until the member has received written notice from the Board that the informational filing is in substantial compliance or complete.

iii. If the Board takes no action within 30 days of a member's submission of information requested by the Board to complete an informational filing, the filing shall be deemed to be in substantial compliance.

11:21-4.1 Policy forms

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

(c) In issuing riders pursuant to N.J.A.C. 11:21-3.2(c), members shall use the standard rider forms which are set forth in the Appendix to this chapter as Exhibits H, I and J, as applicable.

(d)-(j) (No change.)

11:21-6.3 Enrollment

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

(c) A small employer carrier may require a report of an eligible employee's health status for the purpose of determining *{or}* the applicability of a preexisting condition limitation in accordance with the Act. The carrier shall require eligible employees to complete the Health Status form approved by the Board and specified in Exhibit S of the Appendix to this chapter incorporated herein by reference.

1. ***{**After the 60th day following the effective date of N.J.A.C. 11:21-7.15*}* ***Beginning on September 11, 1994***, such report may be used only for the purpose of determining the applicability of a preexisting condition limitation in accordance with the Act.

...

11:21-7.15 Permissible rate classification factors

(a) For health benefits plans issued or renewed ***on or*** after *{the 60th day following the effective date of this provision}* ***September 11, 1994***, a carrier shall not differentiate premium rates charged to different small employers for the same health benefits plan except on the basis of age, gender, and geography in accordance with the following restrictions:

1. Age factor categories shall be limited to the following increments: 24 and under; 25-29; 30-34; 35-39; 40-44; 45-49; 50-54; 55-59; 60-64; 65-69; 70 and over.

2. Geographic categories shall be limited to six territories, each consisting of the areas covered by the first three digits of the U.S. Postal Service zip codes or the counties listed below. A carrier shall determine which territory applies to a small employer on the basis of the address of the small employer's principal place of business. The six territories are the following:

i. Territory A consists of zip codes 070-073 or Essex, Hudson and Union counties;

ii. Territory B consists of zip codes 074-076 or Bergen and Passaic counties;

iii. Territory C consists of zip codes 077-079 or Monmouth, Morris, Sussex and Warren counties;

iv. Territory D consists of zip codes 088-089 or Hunterdon, Middlesex and Somerset counties;

v. Territory E consists of zip codes 081, 085-086 or Burlington, Camden, and Mercer counties; and

vi. Territory F consists of zip codes 080, 082-084, and 087 or Atlantic, Cape May, Ocean, Salem, Cumberland and Gloucester counties.

(b) Notwithstanding (a) above, a carrier may differentiate premium rates charged to different small employers for the same standard health benefits plan, whether it be A, B, C, D, E or HMO, on the basis of family structure according to only the following four rating tiers:

1. Employee only;
2. Employee and spouse;
3. Employee and child(ren); and
4. Family.

APPENDIX
EXHIBIT A

PLAN A

[Carrier]

SMALL GROUP HEALTH BENEFITS BASIC POLICY

. . .

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A

. . .

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500 Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18th month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by: a Network Provider	**an Out-Network Provider**
The **Co-Insurance** for this Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

. . .

GENERAL PROVISIONS

. . .

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
   - by amendment or this Policy; or
   - by reason of any provision of law or any government program or regulation; or
   - if this Policy supplements or coordinates with benefits provided by another insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

. . .

CLERICAL ERROR—MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will not invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to this Policy's **Incontestability** section, the true facts

will be used in determining whether coverge is in force under the terms of this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

...

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the action described above as of the Employer's Policy Anniversary.

...

DEFINITIONS

...

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

...

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography and screening tests.

...

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible

...

[Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required.]

...

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;

b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:
a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. this Policy starts right after the old plan ends.

...

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law; or
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

...

EXHIBIT B

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

...

Daily Room and Board Limits

...

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer

...

DEFINITIONS

...

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography and screening tests.

...

EXHIBIT C

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLANS C, D, E]

...

Daily Room and Board Limits

...

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer

...

DEFINITIONS

...

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography and screening tests.

...

EXHIBIT F

PLANS B, C, D, E

[Carrier]

SMALL GROUP HEALTH BENEFITS POLICY

...

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (without Co-Payment)

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

...

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:
- if treatment, services or supplies are given by a Network Provider 20%
- if treatment, services or supplies are given by an Out-Network Provider 40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE PPO (with Co-Payment)

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

. . .

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

- if treatment, services or supplies are given by a Network Provider — None
- if treatment, services or supplies are given by an Out-Network Provider — 30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE POS

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

. . .

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

- if treatment, services or supplies are given by the PCP — None, except as state below
- if treatment, services or supplies are given or referred by a non-referred Provider — 20%, except as stated below

Exception: for Mental and Nervous and Substance Abuse charges

- if treatment, services or supplies are given or referred by the PCP — 5%
- if treatment, services or supplies are given by a non-referred Provider — 25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

. . .

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.
b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. Any date that the extent or nature of the risk under this Policy is changed:
   - by amendment or this Policy; or
   - by reason of any provision of law or any government program or regulation; or
   - if this Policy supplements or coordinates with benefits provided by another insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.
d. At the discovery of a clerical error or misstatement as described below.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

. . .

CLERICAL ERROR—MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will not invalidate coverage which would otherwise be in force, or continue coverage which would otherwise be validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverge is in force under the terms of this Policy.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

. . .

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the action described above as of the Employer's Policy Anniversary.

. . .

DEFINITIONS

. . .

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Policy.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

...

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

...

[Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required, except as stated below.

Exception: Charges for Mental and Nervous Conditions, and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.**

...

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. this Policy starts right after the old plan ends.

...

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of this Policy.

...

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law; or
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

...

EXHIBIT G

HMO PLAN

[Carrier]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT

...

I.-II. (No change.)

III. DEFINITIONS

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EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Contract. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

EMPLOYEE'S ELIGIBILITY DATE.

a. the date of employment; or
b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL OR INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   I. The American Medical Association Drug Evaluations;
   II. The American Hospital Formulary Service Drug Information; or
   III. The United States Pharmacopeia Drug Information.
   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract

with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

[**HEALTH CARE CENTER OR HEALTH CENTER.** A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

...

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

IV. ELIGIBILITY

...

DEPENDENT COVERAGE

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Adopted Children and Step-Children

An Employee's "unmarried Dependent children" include the Employee's legally adopted children, his or her step-children if they depend on the Employee for most of their support and maintenance and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by this Contract as an Employee or
b. on active duty in the armed forces of any country.

...

VIII. COORDINATION OF BENEFITS AND SERVICES

...

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance coverages; nor
e. any plan We say We supplement.

...

IX. CONTRACT HOLDER GENERAL PROVISIONS

...

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to change Premium rates as of any of these dates:

a. any Premium Due Date;
b. any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. any date that the extent or nature of the risk under the Contract is changed:
   1. by amendment of the Contract; or
   2. by reason of any provision of law or any government program or regulation;
d. at the discovery of a clerical error or misstatement as described below.

We will give You 30 days written notice when a change in the Premium rates is made.

TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE

...

THE CONTRACT

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EXHIBIT H
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD/MAIL)**

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT H
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE **(CARD)**

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT H
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE **(MAIL)**

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT I

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

...

EXHIBIT J
PART 1

RIDER FOR PRESCRIPTION DRUG COVERAGE **(CARD/MAIL)**

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:
a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the

Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] for
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

...

EXHIBIT J
PART 2

RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD)

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:
a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] for
a. drugs labeled: "Caution—limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

...

EXHIBIT J
PART 3

RIDER FOR PRESCRIPTION DRUG COVERAGE (MAIL)

Contract Holder:

Group Contract No.:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:
a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

In no event will We provide [or arrange] for
a. drugs labeled: "Caution—limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

...

EXHIBIT V

[Carrier] PLAN A

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

...

SCHEDULE OF INSURANCE PLAN A

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

...

SCHEDULE OF INSURANCE EXAMPLE: PLAN A PPO

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

...

Co-Insurance

...

	If treatment, services or supplies are given by: a Network Provider	**an Out-Network Provider**
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each calendar year** before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

...

GENERAL PROVISIONS

...

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy.

...

DEFINITIONS

...

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

...

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography and screening tests.

...

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

...

[Coinsured Charge Limit

The coinsured charge limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required.]

...

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;
b. the Policy would have paid benefits for the charges, if the Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and
d. the Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy the Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and
b. the Policy starts right after the old plan ends.

...

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:
a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:
a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. any group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance; nor
e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

. . .

EXHIBIT W

[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

. . .

SCHEDULE OF INSURANCE **EXAMPLE PPO (without Co-Payment)**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

. . .

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

- if treatment, services or supplies are given by a Network Provider 20%
- if treatment, services or supplies are given by an Out-Network Provider 40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE **EXAMPLE PPO (with Co-Payment)**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

. . .

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

- if treatment, services or supplies are given by a Network Provider None
- if treatment, services or supplies are given by an Out-Network Provider 30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE **EXAMPLE POS**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

. . .

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Coinsured Charge Limit has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

- if treatment, services or supplies are given by the PCP None, except as stated below
- if treatment, services or supplies are given or referred by a non-referred Provider 20%, except as stated below

Exception: for Mental and Nervous and Substance Abuse charges

- if treatment, services or supplies are given or referred by the PCP 5%
- if treatment, services or supplies are given by a non-referred Provider 25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur **each Calendar Year** before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

[PLAN B]

Daily Room and Board Limits

. . .

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer

. . .

[PLANS C, D, E]

Daily Room and Board Limits

. . .

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:
a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices
- Autologous Bone Marrow Transplant and Associated High Dose Chemotherapy for treatment of breast cancer

...

GENERAL PROVISIONS

...

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy.

...

DEFINITIONS

...

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:

a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information

   recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

Health Benefits Plan means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

...

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography and screening tests.

...

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

...

[Coinsured Charge Limit

The Coinsured Charge Limit is the amount of Covered Charges a Covered Person must incur each Calendar Year before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse Treatment are not subject to or eligible for the **Coinsured Charge Limit.]**

...

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;

b. the Policy would have paid benefits for the charges, if the Policy had been in effect;

c. the Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and

d. the Policy starts right after the old plan ends.

The Covered Person may have satisfied part of the eligibility waiting period under the Employer's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:

a. the Employee was employed by the Employer on the date the Employer's old plan ended; and

b. this Policy starts right after the old plan ends.

...

COVERED CHARGES

...

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of the Policy.

...

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law; or

e. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. any group or group-type hospital indemnity benefits;

d. Supplemental Limited Benefits Insurance; nor

e. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

...

EXHIBIT Y

[Carrier] **HMO PLAN**

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION EVIDENCE OF COVERAGE

...

II. DEFINITIONS

...

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Employees who work on a temporary or substitute basis or who are participating in an employee welfare arrangement established pursuant to a collective bargaining agreement are not considered to be Employees for the purpose of this Group Health Care Plan. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Group Health Care Plan's conditions of eligibility.

EMPLOYEE ELIGIBILITY DATE.

a. the date of employment; or

b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the

FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

I. The American Medical Association Drug Evaluations;

II. The American Hospital Formulary Service Drug Information; or

III. The United States Pharmacopeia Drug Information.

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

HEALTH BENEFITS PLAN. Any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in New Jersey by any carrier to a Small Employer group pursuant to section 3 of P.L. 1992, c.162 (C. 17B:27A-19). Health Benefits Plan excludes the following plans, policies, or contracts: accident only, credit, disability, long term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only, or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, hospital confinement or other Supplemental Limited Benefit Insurance coverage, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (C. 39:6A-1 et seq.).

...

SUPPLEMENTAL LIMITED BENEFIT INSURANCE. Insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

...

III. ELIGIBILITY

...

DEPENDENT COVERAGE

...

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, Your step-children if they depend on You for most of their support and maintenance and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by the Group Health Care Plan as an Employee or
b. on active duty in the armed forces of any country.

...

VII. COORDINATION OF BENEFITS AND SERVICES

...

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits;
d. Supplemental Limited Benefits Insurance coverages; nor
e. any plan We say We supplement.

...

EXHIBIT Z
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD/MAIL)

[Policyholder:

Group Policy No:

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information;
   3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT Z
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

[Policyholder:

Group Policy No:

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT Z
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE (MAIL)

[Policyholder:

Group Policy No:

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

EXHIBIT Z
PART 4

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

[Policyholder:

Group Policy No:

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:
a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:
a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision

of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

...

EXHIBIT AA
PART 1

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(CARD/MAIL)**

Contract Holder:

Group Contract No:

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** Section of the HMO **EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

...

EXHIBIT AA
PART 2

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(CARD)**

Contract Holder:

Group Contract No:

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** Section of the HMO **EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury **or Mental or Nervous Condition** by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

...

EXHIBIT AA
PART 3

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**

Contract Holder:

Group Contract No:

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** Section of the HMO **EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. recommended by a clinical study and recommended by a review article in a major peer-reviewed professional journal.

...

LABOR

(a)

DIVISION OF WORKERS' COMPENSATION

Investigation of Discrimination Complaints Appeal Procedures

Adopted Amendment: N.J.A.C. 12:235-9.4

Proposed: April 18, 1994 at 26 N.J.R. 1591(b) (see also 26 N.J.R. 2777(a)).

Adopted: July 25, 1994 by Peter J. Calderone, Commissioner, Department of Labor.

Filed: July 25, 1994 as R.1994 d.431, **without change**.

Authority: N.J.S.A. 34:1-20; 34:1A-3(e); and 34:15-64.

Effective Date: August 15, 1994.
Expiration Date: May 3, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

12:235-9.4 Investigation of discrimination complaints; appeal procedures

(a) Upon receipt of a complaint for discrimination, the Division shall conduct an investigation and forward the complaint and results of the investigation to the Director within 90 days.

(b) The Director or his or her designee, upon review of the investigative report, shall make a determination as to whether discrimination exists. This determination shall be forwarded to the complainant and the employer within 30 days by certified mail of the receipt of the investigative report.

(c) Any individual who disagrees with the decision of the Director may submit to the Division a written request for a formal hearing to be held in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., N.J.S.A. 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, within 10 days from the date of the receipt of the Director's decision.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF REAL ESTATE APPRAISERS
Educational Requirements for Certification as a Residential Real Estate Appraiser
Adopted Amendment: N.J.A.C. 13:40A-2A.3

Proposed: February 22, 1994 at 26 N.J.R. 902(a).
Adopted: April 12, 1994 by the Board of Real Estate Appraisers, Carmen D. Mistichelli, President.
Filed: July 19, 1994 as R.1994 d.420, **without change.**

Authority: N.J.S.A. 45:14F-8(n).

Effective Date: August 15, 1994.
Expiration Date: December 16, 1996.

Summary of Public Comments and Agency Responses:

The Board received one written comment regarding the proposal from Mike Damato, Executive Administrator, Appraisal Institute, Metro NJ Chapter.

Question was raised as to whether the proposal should be amended to state that the applicant is required to "succesfully" complete 120 classroom hours, and concerning the criteria for the additional 15 classroom hours of courses to be required pursuant to this proposal. The commenter stated that there are very few courses of 15 classroom hours, and asked not only if there must be an examination at the completion of the 15 hours but also if the requirement for 15 classroom hours can be met by taking two one-day seminars on residential subjects.

Pursuant to existing Board regulations governing education requirements for certification as a Real Estate Appraiser (N.J.A.C. 13:40A-2A.3(b)), educational programs must be at least 15 hours in duration, and include an examination.

Credit cannot be granted without passage of the examination; thus, the term "successful" is implicit in the process. Further, the Board notes that there exists a sufficient number of courses with a duration of at least 15 classroom hours that licensees can attend to comply with this rule. The Board also notes that individuals may take courses that exceed 15 credit hours in duration.

Finally, it should be noted that seminars will not qualify as acceptable under the terms of this rule because seminars do not typically include examinations.

Full text of the adoption follows:

13:40A-2A.3 Educational requirements for certification as a residential real estate appraiser

(a) In order to be eligible to take the Board approved examination for the certification of residential real estate appraisers, an applicant shall be required to complete 120 classroom hours, as defined in N.J.A.C. 13:40A-1.2, of courses in subjects related to real estate appraisal. The required 120 classroom hours shall include a course on the Uniform Standards of Professional Appraisal Practice of the Appraisal Foundation, which the applicant shall have taken subsequent to April 27, 1987. Classroom hours completed for the licensed classification may be included within the required 120 classroom hours.

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

(d) The Board may credit various appraisal courses toward the 120 classroom hour educational requirement. Applicants shall demonstrate that their education included coverage of all the topics listed below with particular emphasis on the appraisal of one to four unit residential properties:

1.-15. (No change.)

(e)-(f) (No change.)

TRANSPORTATION

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Route U.S. 206
Mount Olive Township, Morris County
Adopted Amendment: N.J.A.C. 16:28A-1.57

Proposed: June 6, 1994 at 26 N.J.R. 2200(a).
Adopted: July 14, 1994 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: July 19, 1994 as R.1994 d.421, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Effective Date: August 15, 1994.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

16:28A-1.57 Route U.S. 206

(a) The certain parts of State highway Route U.S. 206 described in this subsection shall be designated and established as "no stopping or standing" zones. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs must be erected:

1.-14. (No change.)

15. No stopping or standing in Mount Olive Township, Morris County:

i. Along both sides:

(1) Within the corporate limits of the Township of Mount Olive.

16.-21. (No change.)

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

TREASURY-GENERAL

(c)

DIVISION OF PENSIONS AND BENEFITS
Lost Pension Checks
Adopted Repeal and New Rule: N.J.A.C. 17:1-1.16

Proposed: June 6, 1994 at 26 N.J.R. 2200(b).
Adopted: July 6, 1994 by Margaret M. McMahon, Director, Division of Pensions and Benefits.
Filed: July 15, 1994 as R.1994 d.416, **without change.**

Authority: N.J.S.A. 52:18A-96 et seq.

Effective Date: August 15, 1994.
Expiration Date: May 1, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

17:1-1.16 Lost pension checks

(a) Upon receiving notification that a retirant or other payee has not received a particular check for whatever reason, the Division of Pensions and Benefits shall send the payee an affidavit of non-receipt for completion.

1. Upon receipt of the affidavit of non-receipt, the Division shall send a stop payment order to the bank upon which the check was drawn. However, if theft is alleged, a stop payment order shall be sent to the bank immediately upon notification of the alleged theft.

2. Upon receipt of an acknowledgment from the bank of the stop payment notice, the Division shall issue a replacement check.

3. If the payee refuses to execute the affidavit, the procedure set forth in this subsection will be followed but a replacement check will not be issued until 90 days after the check date have passed.

(b) The Division of Pensions and Benefits, upon being notified that the retirant has not received a particular check, shall review its canceled check file.

1. If the check has been paid, a copy of the check, together with a forged check affidavit, shall be sent to the retirant.

2. Upon receipt from the retirant of the properly executed affidavit and issuance of a credit by the bank to the account, a replacement check shall be issued.

(a)

DIVISION OF PENSIONS AND BENEFITS

Workers' Compensation Reductions

Adopted Repeal and New Rule: N.J.A.C. 17:1-4.32

Proposed: June 6, 1994 at 26 N.J.R. 2201(a).
Adopted: July 19, 1994 by Margaret M. McMahon, Director, Division of Pensions and Benefits.
Filed: July 25, 1994 as R.1994 d.424, **without change.**

Authority: N.J.S.A. 52:18A-96 et seq.

Effective Date: August 15, 1994.
Expiration Date: May 1, 1998.

Summary of Public Comments and Agency Responses:

Written comment was received from Jonus Reilly, Director of Research and Economic Services, New Jersey Education Association, as follows:

"We feel that changing the system to provide a dollar-for-dollar offset for workers' compensation benefits is a major improvement over the current system of highly unpredictable life actuarial reductions.

We have two questions:

1. The actual language discusses only accidental disability retirements and seems to provide only dollar-for-dollar offsets. The description suggests in the last sentence of the summary that some kind of actuarial reduction will apply to accidental disability retirements. We are thus somewhat confused about whether there will still be some kind of actuarial reduction applying to accidental disability retirements.

2. There is no specific mention of ordinary disability. Are ordinary disabilities thus exempt from offsets?

If there are to be no offsets for ordinary disability, and only dollar-for-dollar offsets for accidental disability, the code should so state explicity."

RESPONSE: The statutes governing the various retirement systems permit members to retire while receiving periodic Workers' Compensation benefits. In this event the pension portion of the retirement allowance is subject to reduction as a result of the Workers' Compensation award. N.J.S.A. 18A:66-32.1 stipulates that "the actuarial equivalent of such periodic benefits remaining to be paid shall be computed and will serve to reduce the pension portion of the retirement allowance payable to the retirant...." The statute, therefore, mandates some form of actuarial reduction.

In the past the Division of Pensions and Benefits employed two methods of actuarial reduction to offset disability retirement allowances when retirees received periodic Workers' Compensation benefits. The most common offset involved the use of the present value disability retirement annuity tables to calculate the reduction. This method of calculation was employed whenever the total value of the Workers' Compensation award was known. The result was a lifetime reduction in the pension portion of the retiree's allowance. In those few cases when the termination date of the compensation award was unknown, the pension portion of the monthly retirement allowance was reduced on a dollar-for-dollar basis by the monthly amount of the periodic Workers' Compensation payment received by the retiree. If and when a termination date for the award became available, the reduction calculation was revised to employ the disability retirement annuity tables.

This second method (the dollar-for-dollar reduction) was still considered to be a form of actuarial reduction as required by the statute. The Division is proposing that this second method be utilized in all future calculations of allowance reductions resulting from the payment of periodic Workers' Compensation benefits after retirement.

The Division's former use of the present value disability retirement annuity tables to calculate the retirement allowance reduction had the advantage of administrative ease and usually resulted in a lesser monthly reduction than would be achieved from a dollar-for-dollar offset. The lifetime nature of the reduction disadvantaged long-lived pensioners, who over time, lost more in retirement allowance reductions than they received from the Workers' Compensation award. Further, the lifetime reductions caused some pensioners economic hardship because the reduction in the retirement allowance continued even though the pensioner was no longer receiving any periodic Workers' Compensation benefit. The Division believes the proposed method of actuarial reduction will be more equitable to its pensioners.

The proposed rule details the method of future calculations for actuarial reductions due to Workers' Compensation awards for individuals who are retired under the accidental disability retirement provisions of the statutes. Reductions for ordinary disability retirements were deliberately omitted as the Division does not intend to calculate future Workers' Compensation reductions in cases other than accidental disability retirements. While there is a readily apparent link between compensable injury under Workers' Compensation law and the statutes governing accidental disability retirement, the Division believes there is no inherent link between the ordinary disability statutes (which require applicants to meet certain years of service standards) and Workers' Compensation benefits.

Full text of the adoption follows:

17:1-4.32 Workers' compensation; reduction of retirement allowance

(a) A member who retires on an accidental disability retirement under the provisions of the applicable statutes governing the various State-administered retirement systems and who receives periodic benefits under the workers' compensation law after the date of retirement shall be subject to a reduction in the pension portion of his or her retirement allowance in the amount of the periodic benefits received after the date of retirement.

1. The reduction shall be a dollar-for-dollar reduction in the pension portion of the retirement allowance in the amount of the periodic benefits for the time period for which the periodic benefits are received.

2. If an accidental disability retiree receives a retirement allowance without reduction and periodic benefits under the workers' compensation law for any time period after the date of retirement, the retiree shall repay to the retirement system the amount of the pension portion of his or her retirement allowance which should have been subject to reduction under the applicable statute and this rule. The repayment may be in the form of a lump sum payment or scheduled as deductions from the retiree's retirement allowances and pension adjustment benefits, except that, if the retiree does not respond by remitting payment in a lump sum within 60 days, the Division shall establish a repayment schedule. In the event of the death of the retiree before full repayment of the amount required under this rule, the remaining balance shall be deducted from any death benefits payable on behalf of the retiree.

3. The reduction under this rule shall not affect the retiree's pension adjustment benefits or survivor benefits that may be payable upon the death of the retiree.

(b) Any retiree or beneficiary receiving pension adjustment benefits based upon a retirement allowance reduced due to receipt of periodic workers' compensation benefits shall be entitled to receive pension adjustment benefits based upon the full retirement allowance.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Corporation Business Tax
Urban Enterprise Zones; Qualified Business; Credits
Adopted Amendments: N.J.A.C. 18:7-15.1, 15.2, 15.4 and 15.5
Adopted Repeal: N.J.A.C. 18:7-15.3

Proposed: June 6, 1994 at 26 N.J.R. 2203(a).
Adopted: July 15, 1994 by Richard D. Gardiner, Acting Director, Division of Taxation.
Filed: July 18, 1994 as R.1994 d.419, **without change**.

Authority: N.J.S.A. 52:27H-81 and 54:10A-27.

Effective Date: August 15, 1994.
Expiration Date: March 14, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

SUBCHAPTER 15. URBAN ENTERPRISE ZONES ACT

18:7-15.1 General

(a) The New Jersey Urban Enterprise Zones Act, Chapter 303, Laws of 1983, N.J.S.A. 52:27H-60 et seq., approved August 15, 1983, provides for the establishment of up to 10 urban enterprise zones in urban areas suffering from high unemployment and economic distress. P.L. 1985, c.391 made certain changes to eligibility requirements for designation as a zone. P.L. 1988, c.93 modified the definition of a qualified business, made adjustments to the eligibility requirements for the employee tax credit, and provided for an alternative investment tax credit. P.L. 1993, c.367 further modified the definition of a qualified business and provided for the designation of 10 additional enterprise zones. Zones are designated by an Urban Enterprise Zone Authority. The Authority may grant certain corporation tax and other benefits to businesses existing in, or formed in, enterprise zones, which have met the definition of a qualified business. This subchapter of the corporation tax rules sets forth the possible benefits, the necessary definitions, and the procedures for qualifying for any or all of these corporation tax benefits. Rules on the sales and use tax and urban enterprise zones are in N.J.A.C. 18:24-31. For Urban Enterprise Zone Authority rules and policies, see N.J.A.C. 12A:120 and 12A:121.

(b) (No change.)

18:7-15.2 Definitions

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

A "qualified business" means either:

1. (No change.)

2. An entity which, after that designation but during the designation period of 20 years, becomes newly engaged in the active conduct of a trade or business in that zone, and has at least 25 percent of its full-time employees at a business location in the zone, who meet at least one of the following criteria:

i. Resident within the zone, within another zone, or within a qualifying municipality;

ii. Either unemployed, while residing in New Jersey, for a least six months prior to being hired, or recipients of New Jersey public assistance programs, for at least six months prior to being hired;

iii. Determined to be economically disadvantaged pursuant to the Jobs Training Partnership Act, P.L. 97-300 (29 United States Code 1501, et seq.). Section 1503(8) of that Act defines the term as follows:

"The term 'economically disadvantaged' means an individual who (A) receives, or is a member of a family which receives, cash welfare payments under a Federal, state or local welfare program; (B) has, or is a member of a family which has received a total family income for the six-month period prior to application for the program involved (exclusive of unemployment compensation, child support payments, and welfare payments) which, in relation to family size, was not in excess of the higher of (i) the poverty level determined in accordance with criteria established by the Director of the Office of Management and Budget, or (ii) 70 percent of the lower living standard income level; (C) is receiving food stamps pursuant to the Food Stamp Act of 1977; (D) is a foster child on behalf of whom state or local government payments are made; or (E) in cases permitted by regulations of the Secretary (U.S. Secretary of Labor), is an adult handicapped individual whose own income meets the requirements of clause (A) or (B), but who is a member of a family whose income does not meet such requirements."

For purposes of the corporation business tax credits, the "qualified business" must be a corporation. The credits shall not be passed through a partnership doing business in a zone to an unqualified corporation which is a partner in the partnership.

...

"Qualifying municipality" means any municipality in which there was, in the last full calendar year immediately preceding the year in which the municipality makes application for enterprise zone designation, an annual average of at least 2,000 unemployed persons, and in which the municipal average annual unemployment rate for that year exceeded the state average annual unemployment rate; except that any municipality which qualifies for state aid pursuant to P.L. 1978, c.14 (C.52:27D-178, et seq.) shall qualify if its municipal average unemployment rate for that year exceeded the state average annual unemployment rate. The annual average of unemployed persons and the average annual unemployment rates shall be estimated for the relevant calendar year by the Office of Labor Statistics, Division of Planning and Research of the State Department of Labor. For purposes of P.L. 1983, c.303 (N.J.S.A. 52:27H-60 et seq.), the seven municipalities in which the six enterprise zones are to be designated pursuant to criteria according priority consideration for designation of these zones pursuant to section 7 of P.L. 1983, c.303 (N.J.S.A. 52:27H-66) shall be deemed qualifying municipalities.

18:7-15.3 (Reserved)

18:7-15.4 Credits against total tax for new employees and investments in urban enterprise zones

(a) (No change.)

(b) A one-time credit against the tax of $1,500 shall be allowed for each new full-time, permanent employee employed at that location who is a resident of the qualifying municipality (as defined in N.J.A.C. 18:7-15.2) in which the designated enterprise zone is located, or any other qualifying municipality in which an urban enterprise zone is located, who was, immediately before employment by the taxpayer, unemployed for at least 90 days, or dependent upon public assistance as the primary source of income. Further qualifications for this benefit are in (e) and (f) below.

(c) A one-time credit against the tax of $500.00 shall be allowed for each new full-time, permanent employee employed at that location who is a resident of the qualifying municipality (as defined in N.J.A.C. 18:7-15.2) in which the designated enterprise zone is located, or any other qualifying municipality in which an urban enterprise zone is located, who does not meet the requirements of (b) above, and who was not, immediately before employment by the taxpayer, employed at a location within the qualifying municipality in which the qualified business is located. Further qualifications for this credit are in (e) and (f) below.

(d) (No change.)

(e) The enterprise zone employee tax credits provided in (b) and (c) above, shall be allowed in the tax year immediately following the tax year in which the new full-time, permanent employee was first employed by the taxpayer, but shall only be allowed if the employee for whom credit is claimed was employed by the taxpayer for at least six continuous months during the tax year for which the credit is claimed. The credit shall be permitted in any tax year of a 20 year period from the date of designation of the enterprise zone, or in any tax year of a period of 20 tax years from the date within

that designation period upon which the taxpayer is first subject to the corporation business tax under N.J.S.A. 54:10A-1 et seq., whichever is later. The termination of designation as an enterprise zone at the end of the 20 year designation period shall not terminate the eligibility period under this section.

(f) The employee tax credit is available only for new full-time, permanent employees who have been employed by the qualified business for at least six continuous months during the year for which the credit is claimed. For a new employee to be considered a full-time, permanent employee, the total number of full-time, permanent employees, including the new employee, employed by the qualified business during the calendar year must exceed the greatest number of full-time, permanent employees employed in the zone by the qualified business during any prior calendar year since the zone was designated. "Calendar year" means the year the new employees are hired. The comparison is made to the peak employment on any date during the calendar years prior to the calendar year in which the new employees are hired, not the employment level on the last date of prior calendar years. The new employees must then continue to be employed during the following year in which the credit is claimed for six continuous months.

Example 1: ABC Company is a qualified business. The highest number of full-time permanent employees the company has employed in any prior calendar years since the zone was designated was 100. ABC Company employs 100 employees in 1985 and hires five new employees in June 1995. The five new employees reside in the qualifying municipality in which the zone is located and, immediately prior to employment by the qualified business, were unemployed for at least 90 days. The five new employees remain with the company through June 30, 1996. ABC may claim the employee tax credit for the 1996 tax year for the employees hired in 1995. The employees remained employed by ABC Company for at least six continuous months during the year for which the credit is claimed (1996). The five new employees are considered full-time permanent employees because the total number of full-time permanent employees, including the new employees, employed by ABC during the 1995 calendar year (105) exceeded the greatest number of full-time permanent employees employed in the zone by ABC in prior calendar years (100). The total credit is $7500 ($1500 × 5).

Example 2: Same facts as above except that in March 1996 ABC Company terminated two of the employees hired in 1995, and in April 1996 hires three new employees. The new employees reside in the qualifying municipality in which the zone is located and, although they were not unemployed for at least 90 days prior to employment by the qualified business or on public assistance, they were not employed, immediately prior to employment by the qualified business, within the qualifying municipality in which the qualified business is located. The new employees remained with ABC through December 1997. ABC may claim the $1500 credit for tax year 1996 only for the three employees hired in 1995 who were not terminated, since the two terminated employees would not have worked for six continuous months during the year for which the credit is claimed. ABC may claim the $500.00 credit for tax year 1997 for each of the three employees hired in 1996 since they remained with ABC for six continuous months in 1997 and the highest number of employees in 1996 (106) exceeded the highest number of full-time permanent employees (105) in prior calendar years. The $1500 credit could not be claimed for the three employees hired in 1996 because they were not unemployed or on public assistance.

(g) Enterprise zone employee tax credits or enterprise zone investment tax credits under this section shall not reduce the taxpayer's tax liability under N.J.S.A. 54:10A-1 et seq. in any tax year by more than 50 percent or the amount otherwise due, but any unused employee or investment tax credits may be carried forward by the taxpayer to the next succeeding tax year and be applied against 50 percent of that year's tax, but not beyond the 20 year totals set forth in (e) above.

(h) The credit shall not exceed an amount which would reduce the total tax liability below the statutory minimum. For minimum tax see N.J.A.C. 18:7-3.4.

18:7-15.5 Qualification for benefits

There is no formal procedure for registration as a qualified business for the purpose of obtaining the corporation tax benefits. However, each annual CBT-100 Corporation Business Tax Return which claims any urban enterprise zone corporation tax benefits must include proof that it is a qualified business. This proof may consist of a certificate or other proof of status as a qualified business for sales tax purposes under N.J.A.C. 18:24-31. If a sales tax certificate or some other form of proof has not been obtained, the taxpayer should attach a statement setting forth how it qualifies as a "qualified business" as defined in N.J.A.C. 18:7-15.2, with sufficient detail to permit verification by the Division of Taxation.

OTHER AGENCIES

(a)

NEW JERSEY TURNPIKE AUTHORITY

Traffic Control

Adopted Amendments: N.J.A.C. 19:9-1

Proposed: January 18, 1994 at 26 N.J.R. 337(a).

Adopted: July 11, 1994 by the New Jersey Turnpike Authority, Herbert I. Olarsch, Administrative Procedures Officer, Acting Executive Director.

Filed: July 13, 1994 as R.1994 d.414, **without change**.

Authority: N.J.S.A. 27:23-1 and 27:23-29.

Effective Date: August 15, 1994.

Expiration Date: September 13, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

19:9-1.3 Traffic control

(a) (No change.)

(b) No vehicle shall operate an emergency flashing light of any color on the Turnpike except State Police vehicles, the Authority's maintenance and official vehicles, contractors' private vehicles while in the performance of authorized Turnpike duties, vehicles on the Turnpike for the purpose of furnishing authorized towing and other services to disabled vehicles, and all other vehicles performing emergency services, such as ambulances and fire engines, when they are properly in use in the performance of authorized Turnpike duties.

(c) (No change.)

19:9-1.4 Uniform direction of traffic

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

(c) Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized Turnpike duties; provided that no such excepted vehicles shall be operated against the normal flow of traffic or contrary to classification prohibitions so as to create a hazard to other vehicles.

19:9-1.5 "U" turns prohibited

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

(c) Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized Turnpike duties; provided however, that this exception shall be for the sole purpose of crossing from a traffic lane carrying vehicles in one direction to a traffic lane carrying vehicles bound in the opposite direction; and

provided further, that no such excepted vehicles shall make such crossing so as to create a hazard to other vehicles.

(d) (No change.)

19:9-1.6 Parking, standing or stopping on Turnpike prohibited except in case of emergency

(a) No vehicle shall be parked, stopped, loaded or unloaded or allowed to stand on the Turnpike except where otherwise posted or expressly permitted by the Authority. Excepted from the provisions of this section while in the performance of assigned duties are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performances of authorized Turnpike duties, provided that no such excepted vehicles shall be stopped so as to create a hazard to other vehicles.

(b)-(j) (No change.)

19:9-1.7 Use of medial strip prohibited

The medial strip between the traffic lanes of the Turnpike shall not be used for driving upon any part thereof or for crossing between said lanes by vehicles or by persons on foot. Excepted from the provisions of this section are State Police vehicles, the Authority's maintenance and official vehicles and vehicles authorized to furnish towing and other services to disabled vehicles on the Turnpike, and all other vehicles discharging emergency functions, such as ambulances and fire engines, when they are properly in use in the performance of authorized Turnpike duties, provided that no excepted vehicle shall use the medial strip so as to create a hazard to other vehicles.

. . .

19:9-1.9 Limitations on use of Turnpike

(a) Use of the Turnpike and entry thereon by the following, unless otherwise authorized by the Authority, is prohibited:

1.-11. (No change.)

12. Vehicles or combinations of vehicles, including any load thereon, exceeding the following extreme overall dimensions or weights:

i.-ii. (No change.)

iii. Length: semitrailer in excess of 53 feet in length when in a tractor-semitrailer combination, private utility, house-type semitrailer or trailer with a length of any single vehicle in excess of 35 feet, private utility, house-type semitrailer and towing vehicle combination in excess of 45 feet and private utility, house-type trailer and towing vehicle combination in excess of 50 feet.

iv.-v. (No change.)

vi. Notwithstanding the above limitations, no vehicle operated with a tandem trailer combination, commonly known as a "double bottom," with overall individual trailer length in excess of 28 feet 6 inches shall be operated on the Turnpike.

13.-24. (No change.)

25. Omnibuses exceeding 45 feet in length, excluding bumpers, and articulated omnibuses exceeding 61 feet in length, excluding bumpers.

(b) (No change.)

19:9-1.15 Transportation of hazardous materials

(a) (No change.)

(b) The transportation or shipment on the Turnpike of radioactive materials or devices, and transportation of Division 1.1, 1.2, 1.3 and 1.4 explosives, as defined in Part 173 of the regulations of the United States Department of Transportation (49 CFR 173), shall be subject to the prior written approval of the Authority. All applications for such approval shall be made in writing addressed to the Director of Operations and shall provide, to the satisfaction of the Authority, that the shipment shall comply in all respects with the provisions of parts 171 to 178 and 397 inclusive of such regulations (49 CFR 171-178, 397).

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Gaming Equipment
Rules of the Games
Caribbean Stud Poker

Temporary Adoption of Amendments to N.J.A.C. 19:45-1.1, 1.15, 1.20, 1.25; 19:46-1.17 and 1.19 and New Rules 19:45-1.39B, 1.52; 19:46-1.13G and 19:47-16.1 through 16.12

Authority: N.J.S.A. 5:12-5, 69(e), 70(f), 99(a) and 100.

Take notice that the Casino Control Commission shall, pursuant to N.J.S.A. 5:12-69(e), conduct an experiment for the purpose of determining whether a game known as Caribbean Stud Poker is suitable for casino use.

The experiment will be conducted in accordance with temporary rules, which will be posted in each casino participating in this experiment, and will also be available from the Commission upon request.

This test would allow a casino licensee which wishes to participate in the experiment, and which meets all the terms and conditions established by the Commission, to conduct the game of Caribbean Stud Poker in its casino.

This experiment could begin no sooner than August 22, 1994, and continue for a maximum of 270 days from that date, unless otherwise terminated by the Commission or any of the participating casino licensees prior to that time, pursuant to the terms and conditions of the experiment.

Should the temporary amendments prove successful, in the judgment of the Commission, the Commission will propose them for final adoption, in accordance with the public notice and comment requirements of the Administrative Procedure Act and N.J.A.C. 1:30.

(b)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Temporary Shortage of Slot Cash Storage Boxes and Slot Drop Boxes in Slot Machine Bases

Adopted Amendments: N.J.A.C. 19:45-1.17 and 1.42

Proposed: June 6, 1994 at 26 N.J.R. 2213(a).
Adopted: July 21, 1994 by the Casino Control Commission, James R. Hurley, Acting Chairman.
Filed: July 25, 1994 as R.1994 d.422, **without change.**

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(l), 99(a) and 100(c).

Effective Date: August 15, 1994.
Expiration Date: August 15, 1997.

Summary of Public Comment and Agency Response:

COMMENT: The Division of Gaming Enforcement supported adoption of the proposal.

RESPONSE: Accepted.

Full text of the adoption follows:

Agency Note: The adopted text of N.J.A.C. 19:45-1.17(c) and 1.42(c)2 below includes amendments adopted effective June 20, 1994 (see 26 N.J.R. 1440(a) and 2594(b)).

19:45-1.17 Drop boxes, transportation to and from gaming tables; slot cash storage boxes, transportation to and from bill changers; storage in count room or slot machine base

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

(c) All slot cash storage boxes removed from bill changers shall be transported directly to and secured in the count room by a Commission inspector, security department member and a member of the casino accounting department, at a minimum; provided however, that a slot cash storage box removed from a bill changer in order to service the bill changer may be temporarily stored in

the corresponding double-locked base of the slot machine (the compartment of the slot machine containing the slot drop bucket or slot drop box) attached to the bill changer, and shall be replaced and relocked in the bill changer when the repairs are completed. If the repairs cannot be completed and the slot cash storage box cannot be replaced in the bill changer by the end of the repair person's shift, or if the bill changer must be removed from the casino floor, the slot cash storage box shall be removed from the locked slot compartment and transported to the count room in accordance with N.J.A.C. 19:45-1.38.

(d)-(e) (No change.)

19:45-1.42 Removal of slot drop buckets, slot drop boxes and slot cash storage boxes; meter readings

(a) For each slot machine and attached bill changer on the gaming floor, the slot drop bucket, slot drop box and slot cash storage box shall be removed at least once a week on specific days and at times designated by the casino licensee on a schedule which shall be filed with the Commission and the Division. No slot drop bucket, slot drop box or slot cash storage box shall be emptied or removed from its compartment at other than the times specified on such schedule except with the express approval of the Commission. Prior to emptying or removing any slot drop bucket, slot drop box or slot cash storage box, a casino licensee shall notify the Commission and the surveillance department of the transportation route that will be utilized.

1. All slot drop boxes which are not attached to a slot machine or temporarily stored in the base of a slot machine pursuant to (c)2ii below, except emergency slot drop boxes which are not actively in use, shall be stored in the count room in an enclosed storage cabinet or trolley and secured in such cabinet or trolley by a separately keyed, double locking system. The key to one lock shall be maintained and controlled by the security department and the key to the second lock shall be maintained and controlled by the Commission.

2. Emergency slot drop boxes, when not in use, shall be stored in a secured area approved by the Commission, in an enclosed storage cabinet or trolley and secured in such cabinet or trolley by a separately keyed, double locking system. The key to one lock shall be maintained and controlled by the security department and the key to the second lock shall be maintained and controlled by the Commission.

(b) (No change.)

(c) Procedures and requirements for removing slot drop buckets, slot drop boxes and slot cash storage boxes from the casino shall be as follows:

1. (No change.)

2. All slot drop buckets, slot drop boxes and slot cash storage boxes removed from compartments shall be transported directly to, and secured in the count room by the personnel required by N.J.A.C. 19:45-1.17(c), for the counting of their contents; provided, however, that:

i. A slot cash storage box removed from a bill changer in order to service the bill changer may be temporarily stored in the corresponding double-locked base of the slot machine (the compartment of the slot machine containing the slot drop bucket or slot drop box) attached to the bill changer, and shall be replaced and relocked in the bill changer when the repairs are completed. If the repairs cannot be completed and the slot cash storage box cannot be replaced in the bill changer by the end of the repair person's shift, or if the bill changer must be removed from the casino floor, the slot cash storage box shall be removed from the locked slot compartment and transported to the count room in accordance with N.J.A.C. 19:45-1.38; and

ii. A full or inoperable slot drop box shall be replaced with an empty emergency slot drop box, and may be stored in its corresponding double-locked slot machine base until no later than the next scheduled slot drop box pickup; and

3. (No change.)

(d)-(q) (No change.)

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Procedures Governing the Removal of Coin, Slot Tokens and Slugs from a Slot Machine
Definitions

Adopted Amendments: N.J.A.C. 19:40-1.2 and 19:45-1.1
Adopted New Rule: N.J.A.C. 19:45-1.41A

Proposed: April 18, 1994 at 26 N.J.R. 1620(a).

Adopted: July 21, 1994 by the Casino Control Commission, James R. Hurley, Acting Chairman.

Filed: July 25, 1994 as R.1994 d.423, **with a technical change** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 5:12-63(c), 5:12-69(a) and 5:12-99(a)11.

Effective Date: August 15, 1994.

Expiration Date: August 24, 1994, N.J.A.C. 19:40; August 15, 1997, N.J.A.C. 19:45.

Summary of Public Comments and Agency Responses:

COMMENT: Greate Bay Hotel and Casino, Inc., t/a Sands Hotel and Casino, has no objection to the proposal.

RESPONSE: Accepted.

COMMENT: The Division of Gaming Enforcement (Division) objects to proposed new rule N.J.A.C. 19:45-1.41A insofar as it would permit slot attendants and slot mechanics to enter a slot hopper to complete a machine paid jackpot, or to return coin or tokens not credited, of a slot machine which accepts coins or slot tokens in denominations of less than $25.00. The Division recommends that only slot supervisors be permitted to enter the slot hopper for these purposes, as the proposed rule provides in the case of slot machines which accept slot tokens of $25.00 or more.

RESPONSE: Rejected. The new rule is consistent with N.J.A.C. 19:45-1.36(e)1, which provides that any slot machine equipped to accept slot tokens in denominations of $25.00 or more shall be opened only by a slot department supervisor or supervisor therof. The Commission is satisfied that this additional measure of security is required only with respect to these higher denomination slot machines.

COMMENT: The Division also objects to that portion of proposed new rule N.J.A.C. 19:45-1.41A(d) which permits nine slugs to be accumulated in a slot machine prior to the completion and filing of a Slug Report. The Division asserts that the use of a slug in playing a slot machine would result in a violation of N.J.S.A. 5:12-114b(1), a crime of the fourth degree, and notes that, pursuant to N.J.S.A. 5:12-80g, all licensees have a duty to inform the Commission and Division of any action which they believe would constitute a crime. The Division asserts that the finding of a slug in a slot machine indicates a crime has occurred and that a casino licensee is therefore required to immediately report the finding of any slug.

RESPONSE: Rejected. The new rule requires a casino licensee to report the finding of slugs as soon as nine slugs are accumulated in a slot machine. N.J.S.A. 5:12-80g does not require notification of any action which may constitute a violation of the Act to be made immediately. While notification of most possible violations should be made as soon as possible, the Commission does not believe that the finding of a single slug in a slot machine requires immediate notification. The Commission believes that the nine-slug threshold for the filing of a Slug Report strikes a reasonable balance in this situation between the duty of licensees to report possible violations of the Act and the need for the Commission and Division to receive such information in a timely and meaningful manner.

Summary of Agency-Initiated Changes:

The definition of "slug" in N.J.A.C. 19:40-1.2 has been modified slightly to reflect the fact that, although coin may be properly used to activate a slot machine, coin, unlike slot tokens, is not subject to Commission approval pursuant to N.J.A.C. 19:46-1.33.

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

19:40-1.2 Definitions

(a) (No change.)

(b) The following words and terms, when used in these rules, shall have the following meanings, unless the context clearly indicates otherwise.

...

"Slug" means any object*, **other than coin appropriately used to activate play, that is*** found in a slot machine hopper, slot drop bucket or slot drop box *[which]* ***and that*** is not approved pursuant to N.J.A.C. 19:46-1.33.

...

19:45-1.1 Definitions

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

...

19:45-1.41A Procedures governing the removal of coin, slot tokens and slugs from a slot machine hopper

(a) Except as provided in N.J.A.C. 19:45-1.38(d), and (b) through (d) below, no coin, slot tokens, or slugs shall be removed from a slot machine hopper.

(b) If a slot machine malfunctions during a payout and the slot machine cannot be repaired in a timely manner, coin and slot tokens may be removed from a slot machine's hopper in order to complete the slot machine paid jackpot. The coin or slot tokens shall be removed from the slot machine hopper by a slot attendant, slot mechanic or supervisor thereof for slot machines which accept coin or slot tokens in denominations less than $25.00, or a slot department supervisor for slot machines which accept slot tokens in denominations of $25.00 or more. The removal of the coin or slot tokens shall be documented on the Machine Entry Authorization Log pursuant to N.J.A.C. 19:45-1.36(k). Nothing in this section shall preclude a casino licensee from preparing a Jackpot Payout Slip for the amount of coin or slot token owed the patron provided that the payout is completed in accordance with N.J.A.C. 19:45-1.40 and a notation is made on the Jackpot Payout Slip indicating the reason for the slip.

(c) If coin or slot tokens are inserted by a patron and are neither registered nor returned to the patron by the slot machine, a member of the slot department in accordance with (b) above may remove the coin or slot tokens from the slot machine hopper and return them to the patron. The removal of the coin or slot tokens shall be documented on the Machine Entry Authorization Log pursuant to N.J.A.C. 19:45-1.36(k). Under no circumstances shall a casino licensee remove more coin or slot tokens than the maximum number of coin or slot tokens which can be wagered on one handle pull of the slot machine.

(d) Whenever slugs are found in a slot machine's hopper the following procedures and requirements shall be followed:

1. A slot attendant, slot mechanic or supervisor thereof shall, for slot machine denominations less than $25.00, or a slot department supervisor for slot machine denominations of $25.00 or more, immediately remove the slugs from the slot machine hopper and place the slugs into an envelope or container. The individual who found the slugs shall record the asset number and denomination of the slot machine, the quantity of slugs found, the date the slugs were found, and his or her signature on the Machine Entry Authorization Log pursuant to N.J.A.C. 19:45-1.36(k). The envelope or container may be maintained inside the slot machine until the number of slugs in the envelope or container is nine. When the number of slugs in the envelope or container reaches nine or at such other times as may be necessary, the slot attendant, slot mechanic or slot supervisor shall complete a three-part Slug Report which contains, at a minimum, the following:

i. The date and time;

ii. The asset number of the slot machine from which the slugs were removed;

iii. The denomination of the slot machine;

iv. The denomination and quantity of slugs;

v. A brief description of the slugs; and

vi. The signature of the slot attendant, slot mechanic or slot department supervisor completing the Slug Report.

2. Upon completion of the Slug Report required by (d)1 above, the slot attendant, slot mechanic or slot department supervisor shall remove the envelope or container, seal the envelope or container and transport it with the Slug Report to the Master Coin Bank or other location as approved by the Commission. The individual accepting receipt of the slugs shall sign all three parts of the Slug Report. The slot department member shall deliver the original copy of the Slug Report to the Commission's Principal Inspector and the triplicate to the Division's in-house office. The duplicate Slug Report shall remain with the slugs until their destruction.

3. If more than nine slugs are found at any one time in a slot machine's hopper, the slot department member shall place the slugs into the envelope or container and immediately complete the Slug Report required by (d)1 above. The slugs shall be immediately transported in accordance with (d)2 above. The slot department member shall inspect the slot machine and coin mechanism to determine if there is a malfunction. The results of this inspection shall be documented on the Machine Entry Authorization Log pursuant to N.J.A.C. 19:45-1.36(k).

4. All slugs shall be destroyed in accordance with procedures submitted to and approved by the Commission and the Division.

(a)

CASINO CONTROL COMMISSION

Notice of Administrative Correction
Duration of Licenses; Renewal
N.J.A.C. 19:51-1.8

Take notice that the Casino Control Commission has discovered errors in the text of the adopted amendment to N.J.A.C. 19:51-1.8(a) published in the July 5, 1994 New Jersey Register at 26 N.J.R. 2803(a). The adopted text did not include amendments to the subsection which were adopted effective May 2, 1994 at 26 N.J.R. 1846(a). This notice, published pursuant to N.J.A.C. 1:30-2.7, corrects the subsection text, incorporating both amendments.

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

19:51-1.8 Duration of licenses; renewal

(a) Licensure pursuant to N.J.S.A. 5:12-92a is granted for a term of [one year] **two years** for the initial license term and [the first two successive renewals, and] for a term of two years for all subsequent renewals; provided, however, that the Commission shall reconsider the granting of such a license at any time at the request of the Division. Licensure pursuant to N.J.S.A. 5:12-92c and 5:12-102 is granted for **a term of** three years **for the initial license term and for a term of four years for all subsequent renewals**. An application for renewal of a license shall be filed no later than 120 days prior to the expiration of that license.

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

HUMAN SERVICES

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services
Traumatic Brain Injury: Community Service Alternatives

Adopted New Rules: N.J.A.C. 10:49-17.5 and 10:60-5
Adopted Amendment: N.J.A.C. 10:49-17.1

Proposed: April 18, 1994 at 26 N.J.R. 1566(a).

Adopted: July 20, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: July 25, 1994 as R.1994 d.426, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6b(2), 7, 7a, b, and c; N.J.S.A. 30:4D-12; N.J.S.A. 30:4E; 42 CFR 440.70, 170; 1915(c) of the Social Security Act; 42 U.S.C. 1396n.

Effective Date: August 15, 1994.

Expiration Date: August 17, 1997, N.J.A.C. 10:49;
February 19, 1996, N.J.A.C. 10:60.

Summary of Public Comments and Agency Responses:
No comments received.

Summary of Changes Upon Adoption:

The Division, in reviewing the proposed new rules and the approved waiver language as received from the Health Care Financing Administration (HCFA) for the Traumatic Brain Injury Program, has discovered some inconsistencies which are being corrected at the time of adoption. Those changes which do not affect eligibility are as follows:

N.J.A.C. 10:49-17.1(e) identified five waiver programs administered by the Division. With the addition of the "Traumatic Brain Injury" program, the Division now administers six waiver programs, which will be included at N.J.A.C. 10:49-17.1(e).

N.J.A.C. 10:60-5.2(a), which duplicates N.J.A.C. 10:49-17.5(f), was inadvertently omitted from the proposal, and is added upon adoption.

N.J.A.C. 10:49-17.5(f)1 (and 10:60-5.2(a)1) have had language added to ensure that individuals enrolled in the TBI program prior to age 65 will continue receiving services that age has been reached.

Language has been added to N.J.A.C. 10:49-17.5(f)2 (and 10:60-5.2(a)2), which identifies that only those individuals injured over the age of 16 may submit an application to receive TBI program services. This clarification ensures that those individuals receiving traumatic brain injuiries at an earlier age will be able to avail themselves of services provided by the Division of Developmental Disabilities. This modification has been authorized by HCFA which approved the waiver.

This waiver program is small having only 75 slots currently with up to 200 slots as a maximum. Age of on-set limitations are necessary to include those with no options and to prevent filling the program with persons who have options for other services such as those provided by the Division of Developmental Disabilities. Services required by individuals injured from infancy or childhood may differ from those provided under this program. DDD has the responsibility of developing the appropriate services for this group.

At N.J.A.C. 10:49-17.5(n), the phrase "prior to the initiation of the plan" is deleted because the plan of care may be initiated with immediacy by the case manager when the client is in the community. This may be done without official review and approval by the MDO. Each plan is subject to the approval of the MDO after the immediate actions have been taken and may be modified if there are problems or objections.

In proposed N.J.A.C. 10:49-17.5(j), the second sentence references the creation of a waiting list when all slots are filled. The implication of the term "waiting" is that each individual applicant will be given a number which moves forward every time a slot is filled. In reality, individuals accepted into the TBI waiver program are selected on the basis of medical need and readiness to enter the program. The Division therefore believes that "waiting list" may be misleading and set-up unrealistic expectations, and has deleted the sentence.

The number of days provided for out-of-home respite care at N.J.A.C. 10:60-5.5(a)3ii, has been increased to 42 from 30 in accordance with the approved waiver as received from HCFA.

The procedure codes Y7458, Y7459 and Y7463 cited at N.J.A.C. 10:60-5.8(c) were designed to provide continuing care to eligible TBI program recipients beyond eight and 12 hours. However, due to an inadvertent oversight the hours between eight and nine, and 12 and 13 were not correctly identified in the proposal. In order to ensure the continuity of care for the TBI recipient, the Department is clarifying that coverage is provided beyond eight and 12 hours by inserting "greater than" and changing the hours to be eight and 12 rather than nine and 13 which appeared in the proposal. There is no effect on client eligibility or program cost as a result of this change.

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

10:49-17.1 Introduction

(a)-(d) (No change.)

(e) The Division administers the following *[five]* ***six*** Statewide waivers that are described below in N.J.A.C. 10:49-17.2, 17.3, *[and]* 17.4***, and 17.5*** respectively:

1. (No change.)

2. Home and Community-Based Services Waivers for Blood or Disabled Children and Adults (Medicaid's Model Waivers I, II, and III); *[and]*

3. AIDS Community Care Alternatives Program (ACCAP)***; and***

4. Traumatic Brain Injury Program.

10:49-17.5 Traumatic Brain Injury Program

(a) The Traumatic Brain Injury (TBI) Program is a renewable Federal waiver program under Section 1915(c) of the Social Security Act, 42 U.S.C. 1396n, which offers home and community-based services to a recipient with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible recipients to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division of Medical Assistance and Health Services (DMAHS), encourages the development of community-based services in lieu of institutionalization.

(c) The Program is Statewide, with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicant's need for care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver recipients will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63-1.15

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age ***at the time of enrollment***;

2. Have a diagnosis of acquired brain injury ***which occurred after the age of 16***;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS), at N.J.A.C. 10:60-1.2;

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care ... Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

(g) If the individual is dually diagnosed, for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the recipient's care. This decision will be made based on clinical evidence as of onset of injury, and professional evaluation.

(h) Retroactive eligibility shall not be available to waiver recipients for those Medicaid services provided only by virtue of enrollment in the waiver program. Those individuals who are not eligible for Medicaid services in the community prior to enrollment in the TBI Waiver are not eligible for retroactive Medicaid eligibility.

(i) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility identification (MEI) card.

(j) In order for an applicant to be enrolled in the program, a waiver slot must be available. *[When all slots are filled, a waiting list will be developed.]*

(k) Prior to formal application for the TBI waiver, a referral shall be submitted to the Office of Home Care Programs (OHCP) of the Division, which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) recipients shall be referred to the appropriate Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application, which includes the determination of disability, and shall then be referred to the appropriate Medicaid District Office (MDO) serving the recipient's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by OHCP to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, including the referral for determination of disability.

(l) After the applicant has been determined financially eligible, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determination of medical eligibility by the Regional Staff Nurse (RSN).

(m) When the applicant is judged financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the OHCP of the recipient's approval for participation in the program.

(n) The MDO shall review and approve the plan of care prepared by the case manager initially, *[prior to the initiation of the plan,]* and at six month intervals.

(o) If a waiver recipient is categorically eligible for Medicaid services under the State Plan and no waiver services are required as a part of the plan of care, the recipent shall be terminated from the TBI program.

(p) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI Waiver from approved Medicaid providers in accord with an individualized plan of care. (See N.J.A.C. 10:60-5.5 for a description of services.)

(q) An individual shall be terminated from the TBI Waiver Program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level 8 or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

(r) Where termination is sought pursuant to (q) above, an individual shall be afforded the opportunity to request a hearing pursuant to N.J.A.C. 10:49-9.10

SUBCHAPTER 5. TRAUMATIC BRAIN INJURY PROGRAM

10:60-5.1 Purpose and Scope

(a) The Traumatic Brain Injury (TBI) Waiver Program is a renewable Federal waiver program which offers home and community-based services to a recipient with an acquired traumatic brain injury. The purpose of the TBI program is to help eligible recipients to remain in the community, or to return to the community rather than be cared for in a nursing facility.

(b) The waiver, prepared by the Division in response to the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Section 2176, Public Law 97-35 and amendments under P.L. 99-509), encourages the development of community-based services in lieu of institutionalization.

(c) The program is Statewide with slots allocated as individuals, ages 18 through 65, are admitted to the program.

(d) The Division administers the overall program, and has the responsibility for assessing an applicants need or care and, for determining which applicants will be served by the program.

(e) Program oversight shall be provided by the Division of Medical Assistance and Health Services through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS). The delivery of home care services to TBI Waiver recipients will be subject to a post-payment utilization review by professional staff of the Medicaid District Offices in accordance with N.J.A.C. 10:63-1.15.

(f) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age;

2. Have a diagnosis of acquired brain injury;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS);

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care ... Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.

***10:60-5.2 Eligibility criteria**

(a) Applicants for participation in the TBI waiver program shall meet the following medical and financial eligibility criteria:

1. Be not less than 18 nor more than 65 years of age at the time of enrollment;

2. Have a diagnosis of acquired brain injury which occurred after the age of 16;

3. Exhibit medical, emotional, behavioral and/or cognitive deficits;

4. Meet the Division's nursing facility standard care criteria for Pre-Admission Screening (PAS), at N.J.A.C. 10:60-1.2;

5. Have a rating of at least four on the Rancho Los Amigos Levels of Cognitive Functioning Scale (see N.J.A.C. 10:60, Appendix I);

6. Be blind, disabled, or a child under the supervision of the Division of Youth and Family Services (DYFS) and be eligible for Medicaid in the community or be eligible for Medicaid if institutionalized. Persons eligible for the Medically Needy segment of New Jersey Care ... Special Medicaid Programs, or enrolled in Garden State Health Plan, or private Health Maintenance Organizations serving Medicaid recipients are not eligible for this program.

i. There is no deeming of spousal income in the determination of eligibility for this program. While spousal resources are considered in the determination of eligibility, up to one-half of the total resources are protected for the use of the spouse; and

7. Be determined disabled by the Social Security Administration (SSA) or by the Disability Review Unit of the Division, using the SSA disability criteria.*

(b) If the individual is dually-diagnosed; for example, with a head injury and psychiatric illness or developmental disability or substance abuse addiction, a determination will be made during the initial review as to the most appropriate service system to manage the

recipient's care. This decision will be made based on clinical evidence, age of onset of injury, and professional evaluation.

(c) Retroactive eligibility shall not be available to waiver recipients for those Medicaid services provided only by virtue of enrollment in the waiver program.

(d) All applicants determined eligible for the TBI Waiver shall be issued a Medicaid Eligibility Identification (MEI) card.

(e) In order for an applicant to be enrolled in the program, a waiver slot must be available.

10:60-5.3 Application process for TBI waiver

(a) Prior to formal application for the TBI waiver, a referral shall be submitted to the Office of Home Care Programs (OHCP) of the Division which shall review the referral to determine if the individual meets the basic criteria for the program. If it is determined that the individual referred is a potential candidate for the TBI waiver, the following shall occur:

1. Supplemental Security Income (SSI) recipients shall be referred to the appropriate Medicaid District Office serving their county of residence;

2. Children under the supervision of the Division of Youth and Family Services (DYFS) shall be referred to DYFS for the initiation of the formal application. If the recipient has not been determined disabled, DYFS has the responsibility for assuring that the disability determination is completed by the Disability Review Unit. It is then sent to the appropriate Medicaid District Office (MDO) serving the recipient's county of residence; and

3. Individuals who are not currently Medicaid eligible shall be referred by OHCP to the county welfare agency (CWA) located in the county where the individual resides, for a determination of financial eligibility, which includes the referral for disability determination.

(b) After the applicant has been determined financially eligible for Medicaid, he or she shall be referred to the Medicaid District Office (MDO) of the applicant's residence for a determination of medical eligibility by the Regional Staff Nurse (RSN). The need for nursing facility care and the continued need for waiver services shall be conducted by the RSN after six months and at the end of the first year of client eligibility and subsequently this determination shall be performed by the case manager.

(c) When the applicant is determined financially and medically eligible for the TBI waiver program, the MDO shall assign the case to a case management site and notify the OHCP of the recipient's approval for participation in the program.

(d) The MDO shall review and approve the plan of care prepared by the case manager initially and at six month intervals. Program oversight shall be provided by the Division through the Office of Home Care Programs (OHCP) and the Surveillance Utilization Review Subsystem (SURS), and the delivery of services will be subject to a post-payment utilization review, per N.J.A.C. 10:63-1.15.

10:60-5.4 Termination criteria for the TBI waiver

(a) An individual shall be terminated from the TBI waiver program for the following reasons:

1. He or she no longer meets the income and resource requirements for Medicaid;

2. He or she no longer exhibits medical, emotional, behavioral and/or cognitive deficits which would qualify the individual for nursing facility care;

3. He or she attains a Level eight or above on the Rancho Los Amigos Levels of Cognitive Functioning Scale;

4. He or she refuses to accept case management services; or

5. He or she is categorically eligible for Medicaid State Plan services and does not require waiver services as part of the plan of care.

10:60-5.5 TBI waiver services

(a) All approved services under the New Jersey Medicaid program, except for nursing facility services, are available under the TBI waiver from approved Medicaid providers in accord with an individualized plan of care. Additionally, the following waiver services shall be available to the eligible recipient:

1. Case management services is a process in which a social worker with a Bachelor of Social Work (BSW), or Master of Social Work (MSW), or a nurse with a Bachelor of Science in Nursing (BSN), or Master of Science in Nursing (MSN), or a certified rehabilitation counselor (CRC), or a certified insurance rehabilitation specialist (CIRS), employed by a licensed Medicare-certified home health agency or a private incorporated case management consulting firm or a non-profit human service agency, is responsible for planning, locating, coordinating and monitoring a group of services designed to meet the individual needs of the recipient being served.

i. Case management shall not be provided when a recipient is in an inpatient hospital or nursing facility setting and the stay extends beyond a full calendar month.

ii. Case management shall include discharge planning and arrangements for other services when the recipient is no longer appropriate for waiver services.

iii. Acceptance of case management services shall be required for program participants.

2. Personal care assistant services are health related tasks performed in the recipient's home or place of residence by a certified homemaker/home health aide who is under the supervision of a registered professional nurse. The frequency or intensity of supervision shall be designated by the plan of care. Tasks shall include assistance with eating, bathing, dressing, personal hygiene, activities of daily living. They may include assistance with meal preparation, but not the cost of the meal itself. When specified in the plan of care, this service shall also include such housekeeping chores as bedmaking, dusting and vacuuming, which are essential to the health and welfare of the recipient. A personal care assistant shall be under contract to, or employed by a licensed Medicare certified home health agency or accredited homemaker/home health aide agency or a community residential services provider (see (a)9 below). Personal care assistant services shall be provided consistent with Medicaid program limitations of hours in accordance with N.J.A.C. 10:60-1.9(f). Family members who provide personal care assistant services shall meet the same standards as providers who are unrelated to the recipient.

3. Respite care service is care provided on a short term basis because of the absence or need for relief of those persons normally providing the care. Respite care shall be provided in the recipient's home or place of residence. Services shall also be provided in a licensed nursing facility, licensed residential health care facility, or by a community residential services program. A community residential services program shall be licensed by the Division of Developmental Disabilities. Home health agencies providing respite care shall also be licensed by the Department of Health and homemaker/home health aide agencies providing respite care shall be accredited in accordance with N.J.A.C. 10:60-1.2.

i. In-home or place of residence respite care shall be provided up to 14 days per year.

ii. Out-of-home respite care shall be provided up to *[30]* **42** days per year.

iii. A community residential services program shall provide respite service to individuals living with their families but this service is not available to recipients residing in a community residential service setting.

4. Environmental modification services are physical adaptations to the recipient's home, required by the recipient and included in the plan of care, which are necessary to ensure the health, welfare and safety of the recipient, or which enable the recipient to function with greater independence in the home, without which the recipient would require institutionalization. Such adaptions shall include the installation of ramps and grabbers, widening of doorways, modification of bathrooms, or installation of specialized electric and plumbing systems necessary to accommodate medical equipment and supplies for the recipient's welfare. Vehicle modification for the recipient's/family vehicle shall also be included. Also included shall be electronic monitoring systems to protect the recipient's safety, as determined by the plan of care. Excluded are adaptions or improvements to the home which are not of direct medical or remedial benefit to the recipient, such as carpeting, roof repair, and/or central air condition-

ing. All environmental modification services provided shall be in accordance with applicable State and local building codes.

i. Case managers shall be responsible to assure that contractors are qualified to provide the necessary modifications.

ii. A provider of environmental modification services shall be required to execute a purchase agreement for the service with the case manager who shall submit a claim for the service to the Division's Fiscal Agent.

5. Transportation services are offered to enable recipients to gain access to services described in the plan of care. A transportation service is offered in addition to medical transportation provided under 42 CFR 431.53 and transportation offered under the State Plan as defined at 42 CFR 440.170(a), and shall not replace them. Whenever possible, family, neighbors, friends, or community agencies that are able to provide this service without charge shall be utilized. Family members shall not be reimbursed for the provision of transportation services under this waiver, in accordance with N.J.A.C. 10:50.

i. Providers of this service shall include community residential services providers, community mental health agencies, family services agencies, Commission on Accreditation of Rehabilitation Facilities (CARF) certified day programs.

ii. All drivers or carriers shall have a valid driver's license and not less than the minimum insurance coverage required by New Jersey law.

iii. Vehicles utilized shall be properly registered and pass inspection standards for bus, taxicab and other commercial carriers or private automobile and can be either regular or specially equipped for those unable to use common carrier transportation.

iv. Reimbursement paid to the transportation provider shall include the cost of the transportation plus the additional cost of the personal care assistant or companion if any, who may accompany the recipient, as long as that person is not a family member. In no case shall a family member be reimbursed for transportation services under the waiver.

v. Transportation shall be covered in the service package provided by a community residential services provider to a recipient living in a supervised residence. No additional reimbursement shall be paid for this service.

vi. Transportation shall be covered in the service package provided by the structured day program during the hours the recipient is participating in the program. No additional reimbursement shall be paid for this service.

6. Chore services are services needed to maintain the home in a clean, sanitary and safe environment. These services shall include heavy household chores, such as washing floors, windows and walls, tacking down loose rugs and tiles, moving heavy items of furniture to provide safe access for the recipient inside the home, shoveling snow to provide access and egress. These services shall be provided only where neither the recipient nor any other person in the household is capable of performing or financially providing for them, or when a relative, caretaker, landlord or community volunteer agency or third party payer cannot provide them. Prior to approving chore services for rental property, the case manager shall determine if it is the responsibility of the landlord to provide these services.

i. Services shall be provided by accredited homemaker/home health aide agencies, county service agencies, employment or cleaning service agencies licensed by the Division of Consumer Affairs, Department of Law and Public Safety. The case manager shall assure that the chore service provider meets all applicable laws, rules and regulations.

ii. Chore services shall be covered in the service package for anyone living in a community residential service provider residence. No additional reimbursement shall be paid for this service.

7. Companion services are non-medical care, supervision and socialization provided to a functionally and mentally impaired adult. A companion shall assist the recipient with such tasks as meal preparation, laundry, and shopping, but shall not perform these activities as discrete services. This service shall not entail hands-on medical care. A companion shall perform light housekeeping incidental to the care and supervision of the recipient. Companion service shall be provided in accordance with a therapeutic goal of engaging the recipient to the extent possible with his or her own care, surroundings and other people. Companion services are appropriate for those recipients who need a person to be with them to provide prompting or cuing to initiate or complete daily activities. Companions provide assistance with shopping and meal preparation, and are available for socialization or to encourage socialization, depending upon the individual's care plan. Companion services may be a less costly service approach to enabling a recipient to remain in the community.

i. Companion service shall be provided by an accredited homemaker/home health aide agency, a private non-profit community service agency, community mental health agency, family service agency, a community residential services provider, or a Commission on Accreditation of Rehabilitative Facilities (CARF) accredited day program.

ii. Companion service shall be covered under a Community Residential Services Program when the recipient is residing in the CRS program and companion services is not reimbursed as a separate service. Companion service shall not be reimbursed as a separate service during the hours the recipient is participating in a structured day program.

iii. The case manager shall insure that the companion meets the following standards:

(1) Is able to read, write and follow simple directions;

(2) Passes a post-employment-offer physical exam prior to placement;

(3) Works under the intermittent supervision of the employment agency;

(4) Is able to handle emergency situations;

(5) Understands and is able to work with individuals with TBI;

(6) Maintains confidentiality; and

(7) Has a valid driver's license and appropriate insurance coverage, if responsible for transporting residents.

8. Therapy services include physical and occupational therapy, speech-language pathology and cognitive therapy services. Therapies shall be offered alone or in combination to enhance or maintain recipient functioning as required by the plan of care. Therapies shall focus on the reattainment of physical or cognitive skill lost or altered as a result of trauma. The aim is to maximize recipient functioning in real world situations through retraining, use of compensatory strategies and orthotic and prosthetic devices, if necessary.

i. Physical therapists (PT) and physical therapy assistants (PTA) shall meet the New Jersey licensure standards and requirements for practice (see N.J.A.C. 13:39A). PT and PTA shall be under contract to or on the staff of a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the PT services.

ii. An occupational therapy provider shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of an OTR. An OTR and COTA shall be under contract to or on the staff of a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the OT services.

iii. A speech-language pathologist provider shall be licensed by the State of New Jersey (see N.J.A.C. 13:44C). A speech-language pathologist shall be under contract to a community residential services provider, rehabilitation hospital or agency, or home health agency, which shall be reimbursed for the speech-language therapy services.

iv. A cognitive therapy provider shall meet certification standards for cognitive therapy, established by the Society for Cognitive Rehabilitation Inc. (Society for Cognitive Rehabilitation, P.O. Box 33548, Decatur, GA 30033-0548, phone, 404-939-6338) and shall be under contact to a community residential services provider, rehabilitation hospital or agency which shall be reimbursed for the cognitive therapy services.

9. Community residential services (CRS) is a package of services provided to a recipient living in a community residence owned,

rented or supervised by a licensed community residential services provider.

i. The package of services shall include personal care, companion services, chore services, transportation, night supervision and therapeutic activities. The reimbursement for this service to the CRS provider does not include room and board or a personal needs allowance (PNA). The recipient shall be responsible for the costs of room and board. The CRS shall not be reimbursed when the recipient is absent from the residence for a 24-hour period since the cost of such absence has been incorporated into the per diem CRS rate.

ii. The CRS provider shall be responsible for coordinating the package of services to ensure the recipient's safety and access to these services as determined by the recipient and case manager.

(1) The CRS program shall be licensed by the Division of Developmental Disabilities as a CRS provider;

(2) Employees of CRS providers shall meet all applicable professional standards; and

(3) All employees shall be trained to understand and provide appropriate care to head injured individuals.

10. Night supervision services include intermittent or ongoing overnight supervision to an individual in his or her own home for a period of not less than eight hours and not more than 12 hours. Night supervision staff shall be trained and supervised by CRS providers or home health or homemaker home health aide agencies to provide supervision and are prepared to call for assistance in the event of an emergency. They shall also be available to perform turning or repositioning tasks, to remind the patient to take medication and to assist with personal care, if needed. It is expected that one night support attendant shall provide assistance for up to three recipients in the same household. Night supervision is not available for recipients receiving CRS in a community residential services program, since supervision is provided as a component of the program:

i. This service shall be provided by a community residential service provider, a home health or homemaker/health aide agency provider.

ii. CRS providers shall be licensed by the Division of Developmental Disabilities (DDD); home health agencies shall be licensed by the Department of Health (DOH); and homemaker/home health aide agencies shall be accredited in accordance with N.J.A.C. 10:60.

11. Structured day program services is a program of daily meaningful supervised activities directed at the development and maintenance of independence and community living skills. Services may take place at home or in a setting separate from the home in which the recipient lives. Services shall include group or individualized life skills training that will prepare the recipient for community reintegration, including attention skills, task completion, problem solving, safety and money management. The services shall include nutritional supervision, health monitoring and recreation as appropriate to the individualized plan of care. The service shall cover transportation during the hours of participation in the program, including transportation to program activities. The program shall be provided in half day (a minimum of three hours) or full day (a minimum of six hours, including lunch) segments. The program excludes Medical Day Care which may be provided as a State Plan service. This service is not otherwise available under a program funded under the Rehabilitation Act of 1973, P.L. 94-142. Recipients are not eligible to receive this service if they are participating in programs for the same time period funded by other agencies.

i. Structured day programs shall be provided by CRS, rehabilitation hospitals or agencies, comprehensive outpatient rehabilitation facilities (CORF) and incorporated head injury service providers which have post-acute day programs that meet standards for post-acute head injury services developed by the Head Injury Special Interest Group of the American Congress of Rehabilitation Medicine or Commission on Accreditation of Rehabilitation Facilities (available from the Division through the Office of Home Care Programs, CN 712, Mail Code 35, Trenton, NJ 08625-0712).

12. Supported day program services is a program of independent activities in-home or out-of-home requiring initial and periodic support from a professional to sustain the program. Interventions shall include placement development, evaluation, and counseling, placement and follow-up in a setting where the setting itself is not paid to supervise the recipient. The professional shall be a person trained and licensed or certified in a specific profession. Examples include, but are not limited to, social work, vocational rehabilitation, psychology, nursing and therapeutic recreation. The program of activities shall promote independence and community reintegration. The professional support shall be reimbursed on an hourly basis, depending on the amount of support required within the plan of care. This service is not otherwise available under a program funded by either the Rehabilitation Act of 1973, or P.L. 94-142.

i. Supported day program staff employed by the day program are paid to develop and monitor a community-based placement for the individual recipient as part of the plan of care. The community-based placement is not paid to provide the activity to the recipient. Examples include prevocational settings, volunteer programs or social clubs where the recipient can participate in meaningful activities. The supported day program provider is paid on an hourly basis for activity development and follow-up to ensure that the recipient has made a satisfactory adjustment in the placement. Supported day program is a step-down alternative to stuctured day program and a less costly service.

(1) "Placement development" means the identification of and negotiation with an organization, business, association or other group in the community to accept a brain injured person to participate in or engage in some productive activity as a part of that group. The activity shall be related to the brain injured person's skills, interests and abilities.

(2) "Evaluation and counseling" means review of the supported day program to determine that the placement is suitable for the recipient, and availability to the recipient and the community program to resolve any problems or to support the recipient's placement.

(3) "Placement and follow-up in the setting where the setting is not paid to supervise the recipient" means that the supported day program provider arranges the placement, provides intervention if there are problems, but will not provide ongoing supervision of the recipient at his or her activity site.

ii. Supported day program services shall be provided as an alternative to structured day program, when the recipient does not require continual supervision.

iii. The providers of supported day program services shall be the same as those providing structured day programs.

13. Counseling services shall be provided to resolve intrapsychic or interpersonal conflict resulting from brain injury as an adjunct to behavioral program services in severe cases or for substance abuse problems. Counseling shall be provided to the recipient and family if necessary. Counseling for substance abuse problems shall be provided by a certified alcohol and drug counsel (CADC) familiar with brain injury or by a local alcohol/drug treatment program. Due to the high correlation between TBI and substance abuse, detailed drug/alcohol abuse history shall be obtained by the case manager for each recipient to monitor a potential for substance abuse. Waiver services shall be utilized only if State Plan counseling services for mental health or drug treatment are either unavailable or inappropriate to meet recipient needs.

i. Providers of counseling service shall be licensed mental health professionals, practicing independently, employed by an agency or under contract to an agency. These professionals include psychologists, psychiatrists, social workers and nurses.

ii. Registered professional nurses shall be licensed by the State of New Jersey and certified as a clinical specialist in psychiatric or mental health nursing by the American Nurses Association (N.J.S.A. 45:11-26).

iii. A social worker shall be licensed as a clinical social worker (LCSW) under New Jersey statutes and rules. (N.J.S.A. 45:1-15 and N.J.A.C. 13:44G).

iv. A psychologist shall be licnesed (see N.J.A.C. 13:42) as a clinical psychologist under New Jersey statute, with competencies in areas related to diagnosis and treatment of brain injury.

v. A psychiatrist shall be a physician licensed under the New Jersey Board of Medical Examiners and Board Certified or Board Eligible under the American Board of Psychiatry and Neurology (N.J.A.C. 13:35).

vi. A certified alcohol drug counselor (CADC) shall be certified by the Alcohol and Drug Counselor Certification Board of New Jersey (ADCCBNJ, 90 Monmouth St., Suite One, Red Bank, NJ 07701, Phone 908-741-3835).

vii. All mental health professionals providing counseling services shall have experience and knowledge in treating persons with brain injuries.

14. Behavioral program services is a daily program provided by and under the supervision of a licensed psychologist and by behavioral aides (specialists) trained by a licensed psychologist, which is designed to serve recipients who display severe maladaptive or aggressive behavior which is potentially destructive to the individual or others. The program provided in or out of the home, is time limited and designed to treat the individual and caregivers, if appropriate, on a short term basis.

i. Behavior programming shall include a complete assessment of the maladaptive behavior(s), development of a structured behavior modification plan, ongoing training and supervision of caregivers and behavioral aides (specialists) and periodic reassessment of the plan. The goal of the program shall be to return the individual to prior level of functioning which is safe for himself or herself and others.

ii. Enrollment in the behavioral program shall require prior authorization and recommendation by a licensed clinical psychologist (N.J.A.C. 13:42) or psychiatrist (N.J.A.C. 13:35), with subsequent consultation by same on an as needed basis. The case manager shall also prior-approve the service within the plan of care.

iii. Providers of this service shall be a licensed CRS provider (N.J.A.C. 10:44A and 10:44B), rehabilitation hospital (N.J.A.C. 8:43H), community mental health agency (N.J.A.C. 10:37 and 10:37C), clinical psychologist (N.J.A.C. 13:42), or Board Certified, Board eligible psychiatrist (N.J.A.C. 13:35).

iv. Rehabilitation hospitals shall have been licensed by the Department of Health (DOH) (N.J.A.C. 8:43H).

v. Community mental health agencies shall be approved by the Division of Mental Health and Hospitals (DMHH) (N.J.A.C. 10:37 and 10:37C).

vi. Community residential services providers shall be licensed by the Division of Developmental Disabilities (DDD) (N.J.A.C. 10:44A and 10:44B).

vii. Additionally, to supervise the program, the provider shall employ staff or contract with a Board Certified or Board Eligible psychiatrist or licensed clinical psychologist with two years experience in head injury and/or behavioral programming.

viii. Behavioral aides (specialists) employed to implement the behavior modification program shall possess a high school diploma at a minimum and have 24 hours of behavioral training from a qualified psychologist or psychiatrist. Behavioral aides (specialists) shall also receive an additional 16 hours of training in crisis management during the first 90 days of employment.

10:60-5.6 Program costs

Total program costs in the TBI waiver are limited by the number of community care slots used each year and by costs per recipient. The cost of the recipient service package shall be no more than the cost of institutional care for the recipient determined at a projected weighted cost of institutional care by the Division. The Division may elect to exclude individuals from the waiver program for whom there is an expectation that costs to Medicaid for services under the waiver may exceed the cost of nursing facility care.

10:60-5.7 Basis for reimbursement for TBI services

(a) A fee-for-service reimbursement methodology shall be utilized for TBI waiver services. Providers shall be precluded from receiving additional reimbursement for the cost of these TBI Waiver services above the fee established by the Medicaid program. (See N.J.A.C. 10:60-5.8(c).)

(b) The health insurance claim form 1500 N.J. shall be used when billing for waiver services provided. Refer to the Fiscal Agent Billing Supplement (Appendix A of this chapter) for information in the completion of the 1500 N.J.

(c) Fees for TBI waiver services are established for each service by the Division, after a review of the range of fees charged for the service by providers throughout the State and in other states with similar waiver programs. Once a fee for a particular service has been established, that fee becomes the maximum fee that Medicaid will pay for that service. Providers seeking approval to render that service are subject to this fee ceiling.

10:60-5.8 Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS) for Traumatic Brain Injury Program

(a) The New Jersey Medicaid Program utilizes the Health Care Financing Administration (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this subchapter are relevant only to the Traumatic Brain Injury Program.

(b) The HCPCS procedure codes are used when requesting reimbursement for services provided through the Traumatic Brain Injury Program and when a Health Insurance Claim Form (1500 N.J.) is required.

(c) The HCPCS procedure codes for the Traumatic Brain Injury Program are as follows:

HCPCS Code	Description	Maximum Rates
Y7433	TBI— Case Management, Initial (First Month)	$200.00
Y7434	TBI— Case Management, Continuing (Subsequent Month)	125.00
Y7435	TBI— Community Residential Services (Level I Supervision) 2-4 hours	99.00
Y7436	TBI— Community Residential Services (Level II Supervision) over 4-8 hours	115.00
Y7437	TBI— Community Residential Services (Level III Supervision) over 8 hours	147.00
Y7438	TBI— Structured Day Program (Full Day)	87.00
Y7439	TBI— Structured Day Program (Half Day)	44.00
Y7443	TBI— Supported Day Program (Per Hour)	30.00
Y7444	TBI— Personal Care Assistant Services (Weekdays, per hour)	14.00
Y7445	TBI— Personal Care Assistant Services (Weekends, and Holidays, Per Hour)	17.00
Y7446	TBI— Companion Services (Per Hour)	11.00
Y7448	TBI— Night Supervision (8 hours)	112.00
Y7449	TBI— Chore Services (Per hour)	10.00
Y7453	TBI— Respite Inpatient Variable NF Rate or per day for non-NF	100.00
Y7454	TBI— Personal Care Assistant Services RN Initial Nursing Assessment	35.00
Y7455	TBI— Personal Care Assistant Services, RN Reassessment	35.00
Y7456	TBI— Respite 8 hour day	88.00
Y7457	TBI— Respite 8 hour night	104.00
Y7458	TBI— Respite *[9]* ***greater than 8*** hour to 12 hour day	128.00
Y7459	TBI— Respite *[9]* ***greater than 8*** hour to 12 hour night	144.00
Y7463	TBI— Respite *[13]* ***greater than 12*** hour to 24 hour day	160.00
Y7554	TBI— Physical Therapy (Per Visit)	73.00
Y7555	TBI— Occupational Therapy (Per Visit)	73.00
Y7556	TBI— Speech Therapy (Per Visit)	73.00
Y7557	TBI— Cognitive Therapy (Per Visit)	73.00
Y7558	TBI— Counseling (Behavior) (Per Hour)	65.00
Y7559	TBI— Counseling (Individual/Family) (Per Hour)	65.00
Y7563	TBI— Counseling (Addiction) (Per Hour)	65.00
Y7564	TBI— Behavior Program (Assessment) (Per Hour)	75.00
Y7565	TBI— Behavior Program (Psychologist) (Continuing) (Per Hour)	75.00
Y7566	TBI— Behavior program (Continuing) (Per Hour)	35.00
Y7567	TBI— Transportation (Per Trip) $.25 per mile	
Y7568	TBI— Environmental Modification (Per Service or Item)	1,000.0

APPENDIX I

RANCHO SCALE

Level	Response	Patient Function
I	No response	Patient is completely unresponsive to any stimulus.
II	Generalized response	Patient reacts to the environment, but not as a specific response to the stimulus—responses are often the same despite change of stimuli. The earliest response is often gross movement to deep pain.
III	Localized response	Patient reacts in a specific manner to the stimulus, but may inconsistently turn head to sound, withdraw an extremity to pain, squeeze fingers placed in the hand, or respond to family members more than others.
IV	Confused, agitated	Patient is in a heightened state of activity, but is still severely detached from the surroundings. Internal confusion and very limited ability to learn is combined with short attention span and easy fatigue. The patient is unable to cooperate and may be aggressive, combative, or incoherent.
V	Confused, inappropriate/nonagitated	Patient appears alert and is able to respond to simple commands. Responses are best with familiar routines, people, and structured situations. Distractibility and short attention span lead to difficulty learning new tasks and agitation in response to frustrations. If physically mobile, there may be wandering. Much external structure is needed. Initiation and memory are limited.
VI	Confused, appropriate	Patient shows goal-directed behavior, but still is dependent on external structure and direction. Simple directions are followed consistently and there is carry-over of relearned skills (like dressing), yet new learning progresses very slowly with little carry-over. Orientation is better and there is no longer inappropriate wandering.
VII	Automatic, appropriate	Patient appears appropriate and oriented with familiar settings such as home and hospital, but is confused and often helpless in unfamiliar surroundings. The daily routine can be managed with minimal confusion as long as there are no changes. There is little recall of what has just been done. There is only a superficial understanding of the disability, with lack of insight into the significance of the remaining deficits. Judgment is impaired with inability to plan ahead. New learning is slow and minimal supervision is needed. Driving is unsafe; supervision is needed for safety in the community or in school and workshop settings.
VIII	Purposeful, appropriate	Patient may not function as well as before the injury, but is able to function independently in home and community skills, including driving. Alert, oriented, and able to integrate past and present events. Vocational rehabilitation is indicated. Difficulties dealing with stressful or unexpected situations can arise, as there may be a decrease in abstract reasoning, judgment, intellectual ability, and tolerance of stress relative to premorbid capabilities.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Manual for Hospital Services

Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients

Adopted Amendment: N.J.A.C. 10:52-8.2

Proposed: June 6, 1994 at 26 N.J.R. 2241(a).
Adopted: July 25, 1994 by William Waldman, Commissioner, Department of Human Services.
Filed: July 25, 1994 as R.1994 d.432, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6a(1), 30:4D-7, 7a, b and c; 30:4D-12; 42 CFR 447.251,253.
Agency Control Number: 94-A-18.
Effective Date: August 15, 1994.
Expiration Date: February 8, 1995.

Summary of Public Comments and Agency Responses:

There were three comments on the proposal.

COMMENTS: Kalison and McBride, P.A., Counsellors at Law representing Kimball Medical Center, requests that the Division interpret the proposed amendments as entitling a hospital adding STCF or CCIS beds to receive a full year's distribution regardless of the point in time the amendments were adopted.

Kimball Medical Center directly commented as a disproportionate share hospital that services many low income mentally ill or developmentally disabled clients. They indicate their support of the redistribution of funds among eligible hospitals on the first of the month following adoption (in 1994) and their need for these funds to service these clients.

RESPONSE: The Division will be making the initial redistribution of the funds among eligible hospitals in the month of adoption (in 1994) and the Division intends to adopt the proposal in a timely manner to facilitate the redistribution of funds.

COMMENT: St. Mary's (Passaic) Hospital commented that they supported the proposal in light of their increase in the number clients served and their qualification for distribution of the Subsidy Fund for the Mentally Ill and Developmentally Disabled Clients.

RESPONSE: The agency appreciates the commenter's support for the rules.

Summary of Changes Upon Adoption:

There is one textual change upon adoption. The change is to change the effective date from "on the first of the month following adoption" to be "in the month of adoption," that is, August, 1994. This technical change is made to assure that payments can be made to hospitals in the month of August which has always been the intended effective date of these amendments. The Division did not intend to begin the redistribution of the payments in September.

This change is not substantial enough to require republication. There is no change in the amount of payment to providers. The change will not enlarge or curtail those providers that are entitled to receive this payment.

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

10:52-8.2 Method of payment

(a)-(d) (No change.)

(e) Disproportionate Share Hospitals which service a large number of low income mentally ill or developmentally disabled clients may also be eligible to receive increased disproportionate share payment. The amount of payments to be made to facilities which serve a large number of mentally ill low income clients will be based upon recommendation by the Division of Mental Health

and Hospitals within the Department of Human Services to the Commissioner of the Department of Human Services. This recommendation will identify hospitals essential to preserve the fragile network of mental health providers in the State. The Division of Developmental Disabilities may also recommend an additional payment to facilities who serve a large number of developmentally disabled clients. These additional payments will assure that these low income and special needs clients continue to have access to critical care.

1. The Hospital Subsidy Fund for Mentally Ill and Developmentally Disabled Clients shall be an amount allocated by the Commissioner during the fiscal year for this purpose. It shall be distributed in the following manner:

i. Hospitals who receive funding from the Hospital Relief Subsidy Fund shall only be eligible for a payment from this fund if recognized by the Division of Mental Health and Hospitals and a Short Term Care Facility (STCF) or a Child Community Inpatient Service (CCIS). Payments to STCF and CCIS shall be based upon its distribution of beds for these services times a projection of the cost of providing the service in a state facility. Any hospital adding these beds will be eligible for payments from this fund. The initial redistribution of the funds among eligible hospitals will be carried out *[on the first of the month following adoption]* *[(]*in **August,*** 1994*[)]*. In subsequent years, the redistribution will be carried out in January of each year.

ii. Hospitals who are not STCF or CCIS, but which are under contract with the Division of Mental Health and Hospitals shall receive an allocation of funds based upon the percentage of services provided by the hospital as a percentage of all services provided by all hospitals. The initial redistribution of the funds among eligible hospitals will be carried out *[on the first of the month following adoption]* *[(]*in **August,*** 1994*[)]*. In subsequent years, the redistribution will be carried out in January of each year.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Medical Day Care
Addition of Pediatric Medical Day Care Services
Adopted Amendments: N.J.A.C. 10:65-1.1, 1.2, 1.4, 1.5, 1.7, 1.8, 2.1 and 2.2
Adopted New Rule: N.J.A.C. 10:65, Appendix H—Fiscal Agent Billing Supplement

Proposed: April 4, 1994 at 26 N.J.R. 1427(a).
Adopted: July 20, 1994 by William Waldman, Commissioner, Department of Human Services.
Filed: July 2, 1994 as R.1994 d.427, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6b(17), 7, 7a, b and c; 30:4D-12.

Effective Date: August 15, 1994.
Expiration Date: February 19, 1996.

Summary of Public Comments and Agency Responses:

Comments were received from the Cerebral Palsy League of Union County, William and Myrle Garbe Treatment Center; Visiting Nurse and Health Services, Elizabeth, New Jersey; and the New Jersey Department of Health. Comments and responses are as follows:

Cerebral Palsy League of Union County

COMMENT: The Cerebral Palsy League of Union County, a licensed Pediatric Medical Day Care Center, supports the proposed changes/additions to N.J.A.C. 10:65. It is not often that we, the service providers, are presented with Rules and Regulations that are clearly written and evidently reflect the needs of the client to be served as well as the provider.

RESPONSE: The Division appreciates your interest and concern and will continue to pursue clear, understandable language in proposed rulemaking.

Visiting Nurse and Health Services

COMMENT: Include skilled nursing observation and direct care of a licensed practical or registered professional nurse in N.J.A.C. 10:65-1.1(a), under Purpose and scope.

RESPONSE: The Division feels that the skilled nursing observation and direct care responsibilities are adequately covered at N.J.A.C. 10:65-1.4(a)4, which describes the duties of the nurse.

COMMENT: Portal-to-portal travel time should be included in the minimum of eight hours a day in which pediatric medical day care centers shall provide services in the center—N.J.A.C. 10:65-1.4(b)3i.

RESPONSE: The Division agrees. The phrase "in the center" has been deleted at N.J.A.C. 10:65-1.4(b)3i, to accommodate this request. Care can be provided during travel time, and in the center, for a minimum of eight hours a day.

COMMENT: The correct terminology at N.J.A.C. 10:65-1.4(b)6i(2) should read intermittent urinary catherization, not coronary catherization.

RESPONSE: The Division agrees and this oversight is being corrected during adoption.

COMMENT: Recommend the elimination of the requirement for a maximum daily census of 27 children, as cited at N.J.A.C. 10:65-1.5(b).

RESPONSE: The Division, after careful consideration, has decided to retain this maximum limitation, since it does not believe it would be in the best interest of these medically fragile children to be served in a larger setting. The maximum program size will be reviewed prior to readoption of the chapter after staff has had more experience with this newly served population.

COMMENT: There should be one nurse to every five children (N.J.A.C. 10:65-1.5(b)1).

RESPONSE: Division staff have determined that the requirement of a one to five nurse-participant ratio would be cost prohibitive and would exceed the cost of institutional care. However, it is the Division's opinion that the required staff of two nurses in attendance, plus the requirement for certification in Cardio-Pulmonary Resuscitation (CPR), adequately addresses any crisis situations which may arise.

Department of Health

COMMENT: Concerning N.J.A.C. 10:65-1.5(a)1i(1), the requirement that the administrator-director must have a Master of Science in Nursing (MSN), Bachelor of Science in Nursing (BSN), or Pediatric Nurse Practitioner with recent pediatric experience (PNP) is above that necessary for this position. We recommend deletion of the degree requirements for the registered nurse serving in this position.

RESPONSE: Only after careful consideration did the Division staff determine that a higher education level is required for pediatric medical day care, which is designed to care for technology dependent and medically unstable children. This rationale was based on the fact that the geriatric population in medical day care is generally frail but more medically stable than the highly medically involved pediatric population. The MSN or PNP degrees are optional for the Administrator's position; however, it is felt that a Bachelor of Science degree in Nursing is minimally needed since these children do require a nursing leader with a specialized body of knowledge to provide appropriate administration, direct supervision and care.

COMMENT: Concerning N.J.A.C. 10:65-1.5(a)2, once again, we recommend deletion of the BSN degree requirement.

RESPONSE: Proposed N.J.A.C. 10:65-1.5(a)2 requires that one of the on-duty registered professional nurses shall possess a BSN or at least one-year recent full-time pediatric experience, not both. Since the BSN degree is an option for the medical day care centers, the Division has elected to retain the BSN. This concept was designed in this manner to allow for a new BSN graduate to work with other professional nurses who have pediatric experience so that she or he may learn from and with them at the pediatric medical day care center.

COMMENT: Concerning N.J.A.C. 10:65-1.5(a)3, the qualification for social workers and social work consultants do not comply with recently adopted requirements for licensure or certification of social workers.

RESPONSE: This paragraph has been recodified from N.J.A.C. 10:65-1.5(a)7 and remains unchanged from the current rule. However, social work and social work consultant qualifications will be reviewed at a future time to ensure conformity with all rules of the New Jersey Board of Social Work Examiners.

COMMENT: Concerning N.J.A.C. 10:65-1.5(a)4i, qualifications for the activities consultant do not comply with N.J.A.C. 8:43F.

RESPONSE: This subparagraph has been recodified from N.J.A.C. 10:65-1.5(a)1, and remains unchanged from the current rule. The ac-

tivities consultant position, however, will be reviewed in conjunction with Executive Order No. 66 for refinement or possible deletion.

COMMENT: Concerning N.J.A.C. 10:65-1.5(a)6, we recommend deletion of the requirement that the Pharmaceutical Consultant be certified by the Joint Board for Certification of Consultant Pharmacies.

RESPONSE: This paragraph remains unchanged from the current rule. The requirement for certification of the Pharmaceutical Consultant will be reviewed in conjunction with Executive Order No. 66 (sunset provision) in the near future.

COMMENT: Concerning N.J.A.C. 10:65-1.5(b), we recommend that an additional nurse be present for each five children attending.

RESPONSE: Division staff, after careful consideration, have determined that the ratio of one nurse to every five children would be cost prohibitive for a community-based service, designed to serve as a health care alternative. Additionally, the Division feels that the required staff of two nurses in attendance, plus the requirement for CPR certification adequately addresses any crisis situation which may arise.

COMMENT: We recommend that staff be certified in the course, "CPR for Health Care Providers," offered by the American Heart Association. We also recommend policies on employee physicals as well as Rubella, Rubeola and Mantoux tuberculin skin tests.

RESPONSE: Concerning N.J.A.C. 10:65-1.5(c), the Division does not recommend agency specific cardio-pulmonary resuscitation course for attendance by pediatric medical day care staff. It is felt that administrative staff at the day care center have the ability to determine an appropriate program for their staff.

Since Department of Health (DOH) licensure is a prerequisite to Division provider approval, that Department's regulations should reflect those requirements for employee physicals which must be followed by Medicaid providers.

Summary of Changes upon Adoption:

N.J.A.C. 10:65-1.4(b)5v is being deleted upon adoption due to confusing terminology. Individuals in Residential Health Care Facilities (RHCF) do not participate in CCPED or HCEP because:

(1) The Department of Health, in its rules, mandates that a resident of a RHCF must not be in need of the services provided by a nursing facility. All participants in CCPED and HCEP must meet the Medicaid requirement for nursing facility level of care. These are mutually exclusive definitions of the need for health care services.

(2) The Department of Health rules require a RHCF to provide a package of health care services which are essentially the same as those provided in a Medical Day Care program. It would be inappropriate for residents to receive a duplication of these services and for the State to reimburse for similar services.

Therefore, the statement "Since individuals who reside in residential health care facilities are not eligible for CCPED or HCEP Medical Day Care Services are not available to these residents" is not necessary and has been deleted on adoption.

Full text of the changes between the proposal and adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

10:65-1.1 Purpose and scope

(a) The Medical Day Care Program is concerned with the fulfillment of the health needs of Medicaid recipients and/or those who are served under the Division's Home Care Expansion Program and who could benefit from a health services alternative to total institutionalization. Medical day care is a program of medically supervised, health related services provided in an ambulatory care setting to persons who are non-residents of the facility, and who, due to their physical and/or mental impairment, need health maintenance and restorative services supportive to their community living. Pediatric medical day care services are available only for technology-dependent and/or medically unstable children who require continuous, rather than part-time or intermittent, care of a licensed practical or registered professional nurse in a developmentally appropriate environment.

(b) In order to be eligible for services through the Medical Day Care Program, an individual must be eligible for one of the following: community Medicaid, New Jersey Care ... Special Medicaid Programs (including the medically needy segment), certain home care programs including Community Care Program for the Elderly and Disabled (CCPED), Model Waivers, the AIDS Community Care Alternatives Program (ACCAP), the Traumatic Brain Injury Program, or the ABC Program for medically fragile children. Persons enrolled in the Home Care Expansion Program are likewise eligible for medical day care services.

10:65-1.2 Definitions

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

"Administration—medical day care center" means an identifiable administrative unit within the medical day care center headed by a Director/Administrator, responsible for the overall conduct of all day care program activities.

...

"Medical day care center" means an identifiable part of a nursing facility, or a hospital affiliated facility, or a freestanding ambulatory care facility, or such other facility which is licensed by the New Jersey State Department of Health in accordance with its Manual for Standards for Licensure of Adult Day Health Care Facilities, N.J.A.C. 8:43F-2, which possesses a valid and current provider agreement from the Division and which provides services as described at N.J.A.C. 10:65-1.4.

1. "Pediatric medical day care center" means a medical day care center which additionally conforms to N.J.A.C. 10:122 (Department of Human Services, Division of Youth and Family Services) Manual of Requirements for Child Care Centers.

10:65-1.4 Required services

(a) At a minimum, the following services shall be provided by the center for participation in the Medical Day Care Program.

1. (No change.)

2. Dietary services as follows:

i. The nutritional status and dietary needs of each recipient shall be evaluated by a qualified dietitian upon admission to the program. Those recipients on a physician-ordered special diet, or those identified as having specific nutritional needs, shall have an evaluation of their nutritional status every 90 days, except that this evaluation shall be performed every 60 days in a pediatric medical day care center. Results of the assessment and evaluation shall be documented in each recipient's record.

(1)-(3) (No change.)

(4) The pediatric medical day care center shall provide a speech-language pathologist who shall evaluate and monitor each child's ability to chew and swallow food when this is deemed necessary by the center's registered professional nurse and ordered by the attending physician.

ii.-iv. (No change.)

3. Medical services as follows:

i. The center's administrator/director, with the medical director of the center, shall establish written medical and administrative policies governing the provision of medical services to the recipients. The medical director shall be responsible for, but not be limited to, the following:

(1)-(4) (No change.)

(5) Establishing relationships with appropriate personnel in other institutions, such as general or special hospitals, rehabilitation centers, home health agencies, clinics, case management sites, laboratories, and related community resources. This would include, but not be limited to, arrangements for emergency room services unavailable within the center. The pediatric medical day care center must have arrangements for the provision of services by appropriate pediatric specialists (for example pulmonologists, cardiologists); and

(6) (No change.)

ii. The medical day care center shall provide:

(1) A medical evaluation of all recipients, provided or arranged for by the medical director as needed, but at least every six months or in the case of children served in a pediatric medical day care center, every 60 days. The documented components of the medical evaluation for children shall be a history and physical, including developmental status, immunization status, laboratory data and a clear identification of medical needs. (Note: Physician services for

the Community Care Program for the Elderly and Disabled/Home Care Expansion Program recipients are not reimbursed by the New Jersey Medicaid program.)

(A)-(E) (No change.)

(2)-(3) (No change.)

4. Nursing services as follows:

i. A registered professional nurse shall be available on the premises of the medical day care center at all times when the center is operating. Additional registered professional nurses shall be present in centers where the daily attendance exceeds 60 participants. (See N.J.A.C. 10:65-1.5(b) for staff-recipient ratio in pediatric medical day care centers.) The registered professional nurse shall be responsible for the supervision of ancillary nursing staff.

ii. The registered professional nurse shall be responsible for, but not be limited to, the following:

(1) (No change.)

(2) Maintaining the standards of nursing practice including, but not limited to: monitoring of identified medical conditions, administration and supervision of prescribed medications and treatments; coordination of rehabilitative services; development of a restorative nursing plan; monitoring of clinical behavior and nutritional status; assisting with the maintenance or redevelopment of the activities of daily living skills; monitoring growth and development; implementing infection control procedures; and communicating findings to the attending physician;

(3)-(13) (No change.)

iii. (No change.)

5. Personal care services as follows:

i. (No change.)

ii. Personal care services shall include education in and assistance with activities of daily living (ADL) (for example, walking, eating, toileting, grooming) and supervision of personal hygiene. In pediatric medical day care centers for children, activities of daily living include appropriate developmental stimulation, diaper changing and toilet training.

6. Pharmaceutical services as follows:

i. The center shall designate a pharmaceutical consultant who shall be responsible for the following:

(1) (No change.)

(2) Reviewing the records of all recipients at least every 90 days to assure that the medication records are accurate, up-to-date and that these records indicate that medications are administered or self-administered in accordance with physician's orders, except that in pediatric medical day care centers, the review of records shall be every 60 days.

(3) Reviewing records at least every 90 days to assure drug regimen, laboratory tests, special dietary requirements, and foods used or administered concomitantly with other medications to the same recipients, are monitored for potential adverse reaction, allergies, drug interaction, contraindications, rationality, drug evaluation, and test modification; and that all irregularities or recommended changes are documented on the recipient's record and reported to the medical director or attending physician, except that in pediatric medical day care centers, the review of records shall be at least every 60 days.

(4) (No change.)

(5) Devoting a minimum of one hour a month to carry out these responsibilities; maintaining a written record of activities, findings and recommendations.

7. (No change.)

8. Social services as follows:

i. (No change.)

ii. The social work staff shall provide, but not be limited to, the following social services:

(1) (No change.)

(2) Providing individual, family and group counseling in reference to psychological, social, financial, legal, vocational, and educational needs of the recipient;

(3)-(12) (No change.)

9. (No change.)

10. Transportation services as follows:

i. (No change.)

ii. The medical day care center shall accommodate the special transportation needs and medical equipment used by the recipient.

iii. (No change in text.)

(b) A medical day care recipient is a person who is a Medicaid recipient, or a recipient who is served under the Division's Home Care Expansion Program, and who is eligible for services and is diagnosed as having an identifiable medical condition, lacks sufficient social support which impacts negatively on this condition and whose assessed physical and psychosocial needs:

1. Do not require services 24 hours a day on an in-patient basis in a hospital or nursing facility, except under special circumstances;

2. Cannot be met totally in any other ambulatory care setting, such as a physician's office, hospital out-patient department or in a partial care/partial hospitalization program;

3. Require and can be met satisfactorily by a seven-hour, including portal-to-portal travel time, day-long active medical day care program not to exceed five days per week, provided by licensed and non-licensed personnel;

i. Pediatric medical day care centers providing service for technology dependent and/or medically unstable children shall provide services *[in the center]* a minimum of eight hours a day. In exceptional circumstances, if eight hours is contraindicated because of the medical condition of a child, the physician shall have approved no less than five hours attendance and this shall be documented in the child's medical record.

4. Are such that current health status would deteriorate without the direct services and health monitoring available at the center; and

5. Cannot be met while a resident of a residential health care facility (RHCF) setting except as follows:

i. If a resident of an RHCF was in medical day care prior to admission to the RHCF, medical day care services can continue for a limited period to allow for the adjustment into the RHCF;

ii. If a resident of an RHCF requires medical day care to encourage transition into a less structured residential setting such as a boarding home or an independent living arrangement, medical day care can be provided for a limited period;

iii. If a resident of an RHCF has been recently discharged from an acute care facility (general hospital, psychiatric hospital), medical day care services can be available for the purpose of "short term" (as determined by the Division) clinical monitoring; or

iv. If a resident of an RHCF shows evidence of an unstable clinical status which requires a short term structured therapeutic environment, medical day care services are available for a limited period.

[v. Since individuals who reside in residential health care facilities are not eligible for CCPED or HCEP, medical day care services are not available to these residents.]

6. Require continuous nursing services only available in a medical day care center serving technology dependent and/or medically unstable children.

i. A child served in a pediatric medical day care center shall meet the following criteria:

(1) Be technology dependent, requiring life-sustaining equipment or interventions, including a tracheostomy, ventilator, central venous pressure (CVP) line, hyperalimentation gastrostomy tube or a nasogastric tube; or

(2) Need ongoing treatment administered by a licensed registered professional nurse (RN) or licensed practical nurse (LPN) to maintain health, such as nebulizer treatments, administration of oxygen, apnea/cardiac monitoring, intermittent *[coronary]* ***urinary*** catheterization; or

(3) Require the ongoing monitoring and assessment by an RN because of such care needs as seizure disorders or cardiac conditions.

10:65-1.5 Staff

(a) The center shall have adequate staff capability to provide services and supervision to the recipients at all times. The composition of the staff shall depend in part on the needs of the recipients and on the number of recipients the program is serving. At a minimum, the center shall have a medical day care center administrator/director, a registered professional nurse, a social worker, an activities coordinator and a medical director, as well as having a

registered pharmacist, speech language pathologist and qualified dietitian, as consultants. If the freestanding facility has no medical director, a licensed physician shall be appointed to serve in this capacity. Staff employed by a pediatric medical day care center shall have had recent pediatric experience and shall be provided with ongoing training regarding children with special needs. Staffing requirements are as follows:

1. The administrator/director shall be responsible for the overall conduct and management of all program activities and staff on a full-time basis, and;

i. Be a qualified health professional, such as a nursing home administrator, physician, social worker, licensed nurse, licensed physical therapist, occupational therapist, or speech-language pathologist;

(1) In a pediatric medical day care center, the administrator/director shall be a qualified health professional, such as a physician, licensed social worker or licensed clinical social worker with a pediatric concentration; a registered professional nurse with a Master of Science in Nursing (MSN), or Bachelor of Science in Nursing (BSN), or Pediatric Nurse Practitioner (PNP), with recent pediatric experience.

(2) In a medical day care center serving adults, the administrator/director shall be experienced in the care of the elderly and disabled and knowledgeable regarding their physical, social and medical health needs; and

ii. Meet the minimum staff requirements defined by the New Jersey State Department of Health (see N.J.A.C. 8:43F-1.4).

2. The registered professional nurse shall be licensed by the New Jersey State Board of Nursing pursuant to N.J.S.A. 45:11-26 et seq. and shall have at least one year full-time or full-time equivalent experience in nursing supervision and/or nursing administration in a licensed health care facility, as defined by the New Jersey State Department of Health (see N.J.A.C. 8:43F-1.7). In a pediatric medical day care center one of the on duty registered professional nurses shall have, at a minimum, the following credentials:

i. Possess a Bachelor of Science in Nursing degree; or

ii. Have at least one year recent full-time pediatric experience.

3. A social worker shall possess a bachelor's or master's degree from a college or university approved by a state department of education with a major in one of the following: social work, psychology, sociology, or counseling as defined by the New Jersey State Department of Health (see N.J.A.C. 8:43F-1.18). For those persons without a master's degree in social work, at least one year of full-time or full-time equivalent social work experience in a licensed health care facility is required.

i. A social work consultant shall possess a master's degree in social work from a graduate school of social work accredited by the Council on Social Work Education and at least one year of full-time social work experience in a health care facility.

4. The activities coordinator shall meet the requirements of the New Jersey State Department of Health, N.J.A.C. 8:43F-1.13, for a patient activities director.

i. An activities consultant shall possess:

(1) A master's degree in any one of the following: recreation therapy, creative arts therapy, occupational therapy, health care administration, human services, or a related field and two years of experience in patient activities in a health care setting; or

(2) A bachelor's degree from a college or university, approved by a state department of education with a major in recreation therapy, creative arts therapy, occupational therapy or a related field and two years of paid full time experience in a clinical, residential, or community-based therapeutic recreation program, and three years experience as a consultant in a health care setting.

5. The medical director shall provide the medical consultation and supervision of the total health care program provided to the recipients. The medical director shall be licensed as a physician to practice medicine in the State of New Jersey (see N.J.A.C. 8:43-1.16). In a pediatric medical day care center, the medical director shall also be certified by the American Board of Pediatrics.

6. A pharmaceutical consultant shall be licensed by the New Jersey State Board of Pharmacy with a current license to practice in the State of New Jersey in accordance with N.J.A.C. 8:43F-1.14 and certified by the Joint Board for Certification of Consultant Pharmacists.

7. A dietitian shall be responsible for the direction, provision and quality of dietary services. Each dietitian shall be registered or eligible for registration by the Commission on Dietetic Registration (see N.J.A.C. 8:43F-1.6).

(b) For staff-recipient ratio, adequate staff is defined as a ratio of one regular full-time, or full time equivalent, staff person to nine recipients, calculated on the basis of the daily census for medical day care centers serving adults. In pediatric medical day care centers the ratio shall be one staff person to three children. There shall be at least two nurses on the premises of the pediatric medical day care center during all hours of operation. The ratio shall include the center administrator/director and all other personnel (except the medical director) who are involved in direct patient care, excluding volunteers. The maximum daily census in any pediatric medical day care center shall be 27 children.

1. Without compromising the above required staff-recipient ratio of one to nine for medical day care centers serving adults or one to three for pediatric medical day care centers, various staff positions could combine functions within one person, that is, the center administrator/director may be a social worker or activities coordinator, performing dual functions of the director/social worker or director/activities coordinator. In medical day care programs serving adults with 36 or more recipients, the director may not serve a dual function. New adult programs for start-up purposes, or with less than 10 recipients, may have no fewer than two full time staff persons. The registered professional nurse shall occupy one of these positions.

(c) For pediatric medical day care centers, all direct care staff shall have current certification in cardio-pulmonary resuscitation (CPR) and shall have had recent pediatric experience. Those without recent pediatric experience shall be educated by the center in growth and development and in the care of children with special needs. All direct care paraprofessional staff shall have been certified by the New Jersey State Board of Nursing as homemaker-home health aides, or certified by the Department of Health as nurse aides in accordance with N.J.A.C. 8:39. When there are technology dependent children served in the center, a registered professional nurse certified for intravenous administration must be available during the hours of operation.

10:65-1.7 Records

(a) As a minimum, the recipient's chart shall contain the following information:

1.-3. (No change.)

4. A nursing assessment/history, which shall be completed after the first five days of attendance or within a period of one month (whichever is less), and daily nursing observations for the first five days of attendance. A nursing summary and evaluation shall follow every 90 days for medical day care, and every 60 days for a pediatric medical day care center, thereafter, providing appropriate input into the Individualized Multidisciplinary Plan of Care;

i. (No change.)

5. A social assessment history, which shall be completed after the first five days of attendance or within a period of a month (whichever is less), and social summary and evaluation notes every 90 days for medical day care and every 60 days for a pediatric medical day care center;

6. An activity assessment and plan, which shall be completed after the first five days of attendance or within a period of a month (whichever is less), and activity summary and evaluation notes every 90 days for medical day care and every 60 days for a pediatric medical day care center;

7. (No change.)

8. A dietary assessment, which shall be completed within the first five days of attendance or within a period of one month (whichever is less). When the recipient's nutritional status requires dietary intervention, there shall be ongoing monitoring and summary and evaluation notes every 90 days for medical day care and every 60 days for a pediatric medical day care center;

9. A multidisciplinary individualized plan of care, which shall be completed after the first five days of attendance or within a period of one month (whichever is less) and updated every 90 days for medical day care and every 60 days for a pediatric medical day care center, with input from each discipline;

10.-11. (No change.)

(b) The multidisciplinary individualized plan of care shall be written for each recipient, with input from the recipient, family, and interested community agencies. The plan shall state medical needs of the recipient as evaluated by the attending physician, with nursing, social service, activity and other service needs as determined by the center staff, with in-put from community agencies. Overall goals and services to be provided by the center to fulfill the needs expressed shall be indicated.

1. The multidisciplinary individualized plan of care shall:

i. (No change.)

ii. Be updated at least every 90 days, for medical day care, and every 60 days for a pediatric medical day care center, by each discipline;

iii.-iv. (No change.)

(c) (No change.)

10:65-1.8 Basis of payment

(a) The center providing Medical Day Care services shall agree to accept the reimbursement rates established by the Division as the total reimbursement for services provided to the Medicaid recipient and to the beneficiary enrolled in the Home Care Expansion Program (HCEP). In a nursing facility based program, the medical day care per diem rate is 45 percent of that nursing facility's per diem rate. In freestanding centers, the medical day care per diem rate is based on an average of the rates paid to nursing facility medical day care providers, or on a percentage of nursing facility rates in effect as of January 1 and July 1 each year. For hospital-affiliated centers, the medical day care rate is a negotiated per diem rate which shall not exceed the maximum medical day care per diem rate paid to nursing facility-based providers. The reimbursement rates set for any Medicaid recipient or an HCEP beneficiary in medical day care centers shall not exceed charges for non-Medicaid participants. The per diem reimbursement shall cover the cost of all services listed in N.J.A.C. 10:65-1.4 with the following exception:

1. Physical therapy and speech-language pathology services shall not be included in the per diem rate reimbursed for medical day care services. These therapies, when provided by the medical day care center, shall be billed separately on the Health Insurance Claim Form, 1500 N.J.

SUBCHAPTER 2. HEALTH CARE FINANCING ADMINISTRATION COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES

10:65-2.1 Introduction

(a) (No change.)

(b) These codes shall be used when requesting reimbursement for certain Medical Day Care Services.

10:65-2.2 Health Care Financing Administration Common Procedure Coding System (HCPCS) Codes

(a) HCPCS Codes for medical day care services are as follows:

HCPCS	Description
...	
97799	Physical therapy
W9002	Medical day care visit
Z1860	Medical day care visit for the AIDS Community Care Alternatives Program (ACCAP)
Z1863	Medical day care visit for technology dependent children
Z1864	Medical day care visit for medically unstable children

(b) Fees for medical day care centers are pre-approved by the Division, based on the reimbursement methodology described in N.J.A.C. 10:65-1.8, with each center's fees established in accordance with the setting in which the medical day care program is operated.

APPENDIX H

FISCAL AGENT BILLING SUPPLEMENT

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter/manual but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

Unisys Corporation
CN-4801
Trenton, New Jersey 08650-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN-049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Medicaid Only
New Eligibility Computation Amounts
Adopted Amendments: N.J.A.C. 10:71-4.8, 5.4, 5.5, 5.6 and 5.9

Proposed: May 2, 1994 at 26 N.J.R. 1754(a).
Adopted: July 20, 1994 by William J. Waldman, Commissioner, Department of Human Services.
Filed: July 25, 1994 as R.1994 d.428, **without change.**

Authority: N.J.S.A. 30:4D-3; 30:4D-7, 7a, b and c; 42 CFR 435.210 and 435.1005; 20 CFR 416.1163 and 416.2025.

Effective Date: August 15, 1994.
Expiration Date: December 24, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

10:71-4.8 Institutional eligibility; resources of a couple

(a) In the determination of resource eligibility for an individual requiring long term care, the county welfare agency shall establish the combined countable resources of a couple as of the first period of continuous institutionalization beginning on or after September 30, 1989. This determination shall be made upon a request for a resource assessment in accordance with N.J.A.C. 10:71-4.9 or at the time of application for Medicaid benefits. The total countable resources of the couple shall include all resources owned by either member of the couple individually or together. The CWA shall establish a share of the resources to be attributed to the community spouse in accordance with this section. (No community spouse's share of resources may be established if the institutionalized individual's current continuous period of institutionalization began at any time before September 30, 1989.)

1. The community spouse's share of the couple's combined countable resources is based on the couple's countable resources as of the first moment of the first day of the month of the current period of institutionalization beginning on or after September 30, 1989 and shall not exceed $72,660 unless authorized in (a)4 or 5 below. The community spouse's share of the couple's resources shall be the greater of:

i. $14,532; or

ii. One half of the couple's combined countable resources.

2.-9. (No change.)

10:71-5.4 Includable income

(a) Any income which is not specifically excluded under the provisions of N.J.A.C. 10:71-5.3 shall be includable in the determina-

tion of countable income. Such income shall include, but is not limited to, the following:

1.-11. (No change.)

12. Support and maintenance furnished in-kind (community cases): Support and maintenance encompasses the provision to an individual of his or her needs for food, clothing, and shelter at no cost or at a reduced value. Persons determined to be "living in the household of another" in accordance with N.J.A.C. 10:71-5.6 shall not be considered to be receiving in-kind support and maintenance as the income eligibility levels have been reduced in recognition of such receipt. Persons not determined to be "living in the household of another" who receive in-kind support and maintenance shall be considered to have unearned income in the amount of:

$168.67 for an individual
$243.00 for a couple

i. (No change.)

13. (No change.)

(b) (No change.)

10:71-5.5 Deeming of income

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

(g) A table for deeming computation amounts follows:

TABLE A
Deeming Computation Amounts

1. Living allowance for each ineligibile child $223.00			
2. Remaining income amount	Head of Household $223.00	Receiving Support and Maintenance $148.33	
3. Spouse to Spouse Deeming—Eligibility Levels			
1. Residential Health Care Facility	$1,173.36		
b. Eligible individual living alone with ineligible spouse	917.36		
c. Living alone or with others	700.25		
d. Living in the household of another	539.09		
4. Parental Allowance—Deeming to Child(ren)			
Remaining income is:	One Parent	Parent and Spouse of Parent	
a. Earned only	$892.00	$1,338.00	
b. Unearned only	$446.00	$ 669.00	
c. Both earned and unearned	$446.00	$ 669.00	

10:71-5.6 Income eligibility standards

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

(c) Non-institutional living arrangements

1.-4. (No change.)

5. Table B follows:

TABLE B

Variations in Living Arrangement	Medicaid Eligibility Income Standards Individual	Couple
I. Residential Health Care Facility	$ 596.05	$1,173.36
II. Living Alone or with Others	$ 477.25	$ 694.36
III. Living alone with Ineligible Spouse	$ 694.36	
IV. Living in Household of Another	$ 341.65	$ 539.09
V. Title XIX Appoved Facility: Includes persons in acute general hospitals, nursing facilities, intermediate care facilities/ mental retardation and licensed special hospitals (Class A, B, C) and Title XIX psychiatric hospitals (for persons under age 21 and age 65 and over) or a combination of such facilities for a full calendar month.	$1,338.00†	

†Gross income (that is, income prior to any income exclusions) is applied to this Medicaid "cap."

(d) (No change.)

10:71-5.9 Deeming from sponsor to alien

(a)-(d) (No change.)

(e) To determine the amount of income to be deemed to an alien, the CWA shall proceed as follows:

1. (No change.)

2. Subtract $446.00 for the sponsor, $669.00 for the sponsor if living with his or her spouse, $892.00 for the sponsor if his or her spouse is a co-sponsor.

3. Subtract $223.00 for any other dependent of the sponsor who is or could be claimed for Federal Income Tax purposes.

4. (No change.)

(f) (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Public Assistance Manual
Aid to Families with Dependent Children (AFDC)
Readoption with Amendments: N.J.A.C. 10:81
Adopted Repeal: N.J.A.C. 10:81-12

Proposed: April 18, 1994 at 26 N.J.R. 1573(a).

Adopted: July 20, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: July 25, 1994 as R.1994 d.429, **without change.**

Authority: N.J.S.A. 44:10-3, Federal Family Support Act of 1988 (P.L. 100-485), 58 FR 49218, 57 FR 30407, 45 CFR 250.30(b)(a), 45 CFR 250.73(e)1 and 255.2.

Effective Date: July 25, 1994, Readoption;
August 15, 1994, Amendments and Repeal.

Expiration Date: July 25, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:81.

Full text of the adopted amendments follows:

10:81-1.6 Confidential nature of information

(a) Information about applicants or recipients will be used or disclosed only for purposes directly connected with the administration of public assistance and related services, including Title IV-E (foster care and adoption assistance programs), which cannot be offered without such information in accordance with the provisions at N.J.A.C. 10:81-7.31.

1. Such safeguards shall not apply to the furnishing of recipient address information to State and local law enforcement officers attempting to locate a fugitive felon in accordance with the provisions at N.J.A.C. 10:81-7.32(c).

2. Information concerning applicants or recipients may also be released to appropriate individuals in instances involving child abuse

and neglect situations as described at N.J.A.C. 10:81-3.12(e), 7.29 and 7.46(c)2.

10:81-1.7 Nondiscrimination

There shall be no discrimination on grounds of race, color, religion, sex, national origin, marital, parental or birth status, or disability by State or local agencies in the administration of any public assistance program.

10:81-1.12 Other programs

(a) Other related assistance programs include (also see N.J.A.C. 10:81-8):

1.-6. (No change.)

7. Child Care Programs/Services are administered by the Division of Family Development with the goal of assisting both AFDC and non-AFDC individuals in their efforts to achieve self-sufficiency.

i. JOBS/FDP child care benefits as a supportive service to participants actively participating in New Jersey's REACH/JOBS and FDP program are made available as an entitlement. Participants may receive child care benefits as described at N.J.A.C. 10:81-14 to the extent that such child care is necessary to permit an AFDC eligible family member to accept employment, to remain employed or to participate in an educational or employment-directed activity.

ii. JOBS/FDP Transitional Child Care (TCC) benefits, described at N.J.A.C. 10:81-14, are a supportive service available to families whose eligibility for AFDC has ceased due primarily to increased earnings, increased hours of employment (including new employment), which result in increased earnings, or as a result of the loss of earned income disregards due to the expiration of time limits. This supportive service is an entitlement and is available for 12 months post-AFDC, to the extent that child care is necessary to permit a member of the AFDC family to accept or maintain employment. The eligible parent must request such benefits and will be required to pay a co-pay fee based on annual gross income, family size, hours of child care needed and the number of children needing care.

iii. DFD administers, through the county Boards of Social Services, the payment of special circumstance child care utilizing Title IV-A funds. This supportive service benefit is available when payment for such care is not available through other resources and the county Board of Social Services determines, while adhering to established guidelines, that such care is essential. This supportive service and the guidelines are outlined at N.J.A.C. 10:82-5.

iv. New Jersey Cares for Kids (NJCK) Child Care Certificate Program is made possible through block grant monies of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Public Law 101-508. The block grant child care service programs are the At-Risk Child Care (ARCC) Program as implemented by Section 5081 of OBRA 1990, and the Child Care and Development Block Grant (CCDBG) Act of 1990, as implemented by Section 5082 of OBRA 1990. The NJCK Certificate Program is implemented by community child care agencies in each county via contract with DFD. The program is made available to income eligible families to the extent that such child care is necessary to permit a family member to accept employment, to remain employed, or to participate in employment/training/educational activities as specified in Federal regulations. To receive services from this program the family must pay a co-pay fee which is based on gross annual income, family size, hours of care needed and the number of children in care. This program is further described in the DFD Child Care Services Manual at N.J.A.C. 10:15, 10:15A, 10:15B and 10:15C.

8. (No change in text.)

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

10:81-3.9 Applicant in AFDC-C and -F

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

(c) To be eligible for AFDC-C or -F, or AFDC-related Medicaid an individual shall be either a citizen of the United States or otherwise permanently residing in the United States under color of law, including any alien who is lawfully present in the United States as a result of the application of Section 207(c), Section 203(a)(7) (prior to April 1, 1980), Section 208, and Section 212(d)(5) of the Immigration and Nationality Act.

1. Each AFDC-C and -F and AFDC-related Medicaid applicant shall, as a condition of eligibility, provide a written statement of citizenship or legal alien status. If the applicant(s) is not a United States citizen, he or she shall provide documentation, subject to verification, of satisfactory immigration status. When the applicant or other person for whom the application is being made is an alien, his or her legal status shall be verified through evidence provided by the applicant with the United States Immigration and Naturalization Service.

i. (No change.)

ii. If a signature is not provided for all eligible family members by the end of the 30-day processing standard, then only those individuals for whom there is a signature shall be eligible for benefits provided they meet all other eligibility requirements.

iii.-iv. (No change.)

2.-4. (No change.)

10:81-3.18 Work criteria; determination of principal earner

(a) (No change.)

(b) AFDC-F segment eligibility for families with both natural or adoptive parents in the home is based on deprivation of parental support to the children in that family due to unemployment of the parent who is designated the principal earner. Form PA-22, Employment Criteria for AFDC-F families, is to be used by the CWA in determining eligibility for AFDC-F. Form PA-22 may be reproduced by each CWA. After the initial application, the CWA shall reexamine Form PA-22 whenever the circumstances surrounding employment in a two-parent household change. To qualify for AFDC-F, the following criteria shall be met:

1. The principal earner has been unemployed or underemployed for at least 30 days prior to the receipt of public assistance;

i. Unemployed or underemployed is defined as:

(1)-(3) (No change.)

2.-6. (No change.)

7. The principal earner has six or more quarters of work (as described in (b)7i below, no more than four of which may be quarters of work over his or her lifetime as defined in (b)7i(2) below, within any 13 calendar-quarter period ending within one year prior to the application for such aid; or, within such one-year period, received unemployment compensation under an unemployment compensation law of a State or of the United States; or was qualified (see (b)6i above) for such compensation under the State's unemployment compensation law.

i. A "quarter of work" with respect to any individual means a period (of three consecutive calendar months ending on March 31, June 30, September 30, or December 31) in which:

(1) (No change.)

(2) The individual attended full-time, an elementary school, a secondary school, or a vocational or technical training course that is designed to prepare the individual for gainful employment, or in which such individual participated in an education or training program established under the Job Training Partnership Act, Public Law 97-300; or

(3) The individual participated in the Community Work Experience Program or WIN (Work Incentive Program) prior to October, 1990, or the Job Opportunities and Basic Skills Training Program (JOBS/REACH or FDP in New Jersey).

(c) (No change.)

10:81-7.29 Reporting of child abuse and neglect

County welfare agencies are required to report known or suspected instances of child abuse and neglect of a child receiving AFDC to the Division of Youth and Family Services. Instances of abuse and neglect involve situations where a child experiences physical or mental injury, sexual abuse or exploitation or negligent treatment or maltreatment under circumstances which indicate that the child's health or welfare is threatened.

10:81-7.30 Federal policy for safeguarding information

(a) The Federal Social Security Act requires that a State must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of public assistance and related services,

including Title IV-E (foster care and adoption assistance programs), which cannot be offered without such information in accordance with the provisions at N.J.A.C. 10:81-7.31.

1. (No change.)

2. Information concerning applicants or recipients may also be released to appropriate individuals in instances involving child abuse and neglect situations as described at N.J.A.C. 10:81-3.12(e), 7.29 and 7.46(c)2.

10:81-7.36 Nondiscrimination in public assistance programs

Title VI of the Federal Civil Rights Act of 1964 (Public Law 88-352) and Section 504 of the Federal Rehabilitation Act of 1973 prohibit discrimination on the grounds of race, color, national origin, or disability in the administration of any program for which Federal funds are received. Strict compliance with the provisions of these Acts and any regulations based thereon is required as a condition of eligibility to receive Federal funds for assistance programs administered through the county welfare agencies. These principles apply to all public assistance programs in New Jersey.

10:81-7.38 Procedures affecting county welfare agencies

(a) (No change.)

(b) Rules concerning the assurance of compliance by vendors are:

1. All official invoice forms of the county welfare agency shall contain the following statement directly above the vendor's signature.

i. "Services are provided to all recipients without regard to race, color, national origin, sex, marital, parental or birth status, or disability."

2.-3. (No change.)

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

(e) Complaint procedure rules are:

1. All persons seeking or receiving public assistance shall be afforded an opportunity to file a complaint alleging discrimination on the grounds of race, color, national origin, or disability. Such complaints may be filed directly with the Regional Director, U.S. Department of Health and Human Services, Federal Building, 26 Federal Plaza, New York, New York 10007, or with the Director, Division of Family Development, Department of Human Services, CN 716, Trenton, New Jersey 08625.

2.-6. (No change.)

10:81-8.21 Function of Division of Vocational Rehabilitation Services

(a) The function of the Division of Vocational Rehabilitation Services Commission is to provide services to needy and disabled residents of the State, other than those visually disabled, in order that such individuals will be afforded the opportunity to reach the highest possible level of independent functioning through the cure, correction or amelioration of their disabling condition.

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

10:81-10.1 Purpose and funding

(a) (No change.)

(b) Federal financial participation for refugees under RRP is 100 percent. For refugees who meet AFDC-C or -F segment criteria, 50 percent of the Federal reimbursement is from Title IV-A funds and 50 percent from refugee funds subject to the availability of funds. For those refugees meeting AFDC-N or GA criteria, 100 percent Federal financial reimbursement is from refugee funds.

10:81-10.3 INS statuses for RRP

(a) Applicants may be eligible for assistance under RRP if they have been classified in one of the following INS statuses:

1.-4. (No change.)

5. A person from any country who previously held one of the statuses identified in (a)1 through 4 above whose status has subsequently been changed to that of permanent resident alien. In addition to the required form I-151 or I-551 (resident alien forms) showing the status of resident alien, the individual must also provide sufficient documentation to substantiate that one of the eligible statuses indicated in (a)1 through 4 above was held prior to that of resident alien;

6. A person identified as an Amerasian from Vietnam with their close family members admitted in immigrant status under Section 584 of the Foreign Operations Appropriations Act, to be admitted during the two year period authorized by that law, beginning March 20, 1988 and so indicated on Form I-94 or I-551; or

7. A Cuban or Haitian national granted parole for humanitarian reasons or in the public interest; or a Cuban or Haitian national who applies for asylum; or a Cuban or Haitian national who is subject to exclusion or deportation proceedings and a final order of deportation or exclusion has not been issued.

10:81-10.7 Eligibility

(a)-(d) (No change.)

(e) Work and training requirements: Refugees who are under the -C or -F segment of the AFDC program are subject to the work and training requirements governing that program.

1. (No change.)

2. Refugee cases that are under the -N segment of the AFDC program and those considered GA type cases are subject to the work and training requirements detailed in (e)2i through iii below:

i. Work registration: All refugees who are not exempt from the work requirements (see (i)1 below) shall be registered with an Employment Services Provider (ESP). Registration is accomplished through completion and transmittal of Form PA-54, Refugee Program Interagency Referral, to the appropriate ESP. In some instances, however, a refugee may have been referred by a resettlement agency to an ESP which in turn referred the individual to the CWA to apply for assistance. In that instance the ESP will complete Parts A and C of Form PA-54 and provide the individual with a copy to present to the CWA for its files; the CWA need not complete another Form PA-54 for registration purposes.

ii.-iii. (No change.)

(f)-(j) (No change.)

10:81-10.8 Medical assistance and medical expense spend-down

(a) Medical assistance: State eligibility standards for Title XIX shall apply to a refugee's eligibility for medical assistance except:

1.-3. (No change.)

4. The income and resources of sponsors, and in-kind services and shelter provided to refugees by their sponsors, shall not be considered in determining eligibility for medical assistance;

5. All refugees who have been in the U.S. for eight months will no longer be eligible for medical or cash assistance under RRP. Any subsequent update to this eligibility period for medical or cash assistance under RRP will be published as public notice by the Department in the New Jersey Register (see N.J.A.C. 10:81-10.7(b)), and this paragraph revised accordingly as an administrative change; and

6. GA and AFDC-N type refugees who lose eligibility for financial assistance due to increased earnings are eligible for Medicaid extension for up to four months. This four month extension is only allowable during the refugee's first eight months in the country.

(b) (No change.)

10:81-13.2 Eligibility

(a) (No change.)

(b) For AFDC and AFDC-related Medicaid cases a statement and signature for each eligible family member shall be provided to the CWA before benefits can be issued to that individual. An adult eligible family member or applicant for the family in the absence of an adult family member shall sign for members under 18 years of age.

1. If a signature is not provided for all eligible family members by the end of the 30-day application processing standard, then only those individuals for whom there is a signature shall be eligible for benefits provided they meet all other eligibility requirements. Income and resources of ineligible individuals shall be considered in the determination of benefits for the eligible family.

2. (No change.)

10:81-14.3 REACH/JOBS participation

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

(g) REACH/JOBS participation requirements

1.-2. (No change.)

3. "Limited" participation of no more than 20 hours per week in REACH/JOBS activities by the parent or caretaker relative who personally provides care for a child if the child is at least three years of age but under age six, is allowable unless the custodial parent is under age 20 and has not completed a high school education or its equivalent (see (m)1 and 2 below). Only one parent or other relative in a family is allowed this limited participation level (20 hours) in an activity. Child care shall be guaranteed in accordance with N.J.A.C. 10:81-14.18 to enable the 20-hour participation in REACH/JOBS.

(h)-(j) (No change.)

(k) Federal participation requirements: Title II of the Family Support Act, the Job Opportunities and Basic Skills Training (JOBS) program, requires that individuals with certain educational needs or certain family circumstances participate in prescribed employment-directed activities (EDAs) or participate subject to Federal limitations. These requirements are set forth in (l) through (r) below and include:

1.-4. (No change.)

5. Limited participation for a caretaker of a child age three and older but under age six;

6.-7. (No change.)

(l)-(o) (No change.)

(p) Caretaker of child age three and older and under six—limited participation: A parent in an AFDC-C segment case and only one parent in an AFDC-F segment case with a child under six years of age cannot be required to participate for more than 20 hours per week in an employment-directed activity, even if child care is provided. However, the individual may volunteer to participate for greater than 20 hours.

1. (No change.)

(q)-(t) (No change.)

10:81-14.3A REACH/JOBS exemptions

(a) Individuals classified as exempt are not required to participate in employment or in REACH/JOBS employment-directed activities (see N.J.A.C. 10:81-14.3(b)). The following categories of individuals are exempt from participation in REACH/JOBS.

1.-6. (No change.)

7. Caretaker of young child: The parent or other caretaker relative of a child under three years of age who personally provides care for the child, subject to the following:

i. (No change.)

ii. Only one parent or other relative in the family may be exempt from REACH/JOBS participation for the reason of personally providing care to a child under three years of age.

(1) Limited participation of 20 hours in any REACH/JOBS activity is required for one caretaker relative whose child is three years of age or greater, but less than age six (see N.J.A.C. 10:81-14.3(g)3).

8.-11. (No change.)

Recodify existing 13. and 14. as 12. and 13. (No change in text.)

10:81-14.8 Noncompliance; good cause; conciliation; sanctions

(a)-(k) (No change.)

(l) Renewed participation after the sanction period: Individuals who are sanctioned may again participate in REACH/JOBS after the expiration of the sanction period, upon application and indication to the REACH/JOBS case manager of willingness to participate.

1.-3. (No change.)

(m)-(o) (No change.)

10:81-14.13 Vocational assessment and counselling

(a) (No change.)

(b) Parent with a child under age three: A special vocational assessment and counseling component may be required for any parent who is exempt from participation in REACH/JOBS due to care of his or her child under age three. The REACH/JOBS orientation may be used to satisfy this requirement.

1.-2. (No change.)

10:81-14.18 REACH/JOBS support services: child care

(a) General provisions: The general provisions in this subsection apply to all child care benefits available through the REACH/JOBS program, including post-AFDC child care benefits.

1.-3. (No change.)

4. Required coordination: Each county shall coordinate REACH/JOBS child care activities and post-AFDC child care with existing child care resource and referral agencies; with early childhood education programs in the county, including Head Start programs, preschool programs funded under Chapter 1 of the Education Consolidation and Improvement Act of 1981 (P.L. 97-35), school and nonprofit child care programs (including community-based organizations receiving funds designated for preschool programs for disabled children); and with Federal and/or State demonstration programs, such as the Good Starts program, the REACH Capital Expansion Program and the Mini Child Care Center program.

5.-7. (No change.)

(b)-(e) (No change.)

(f) Provider requirements: REACH/JOBS payments to providers of child care are available according to the following conditions:

1.-2. (No change.)

3. Family day care providers—approved homes: Providers of family day care who are not living in the home of the REACH/JOBS participant and who are not registered under (f)2 above shall be approved by the Department of Human Services in order to qualify for payment through the REACH/JOBS program. Unregisterd relatives, friends or neighbors are eligible for approved home status.

i. The minimum requirements for approval of the home are an inspection of the home using the "Self-Arranged Care Inspection and Interview Checklist" (see Appendix A, incorporated herein by reference), and standard interview procedure with the provider and family members.

ii. (No change.)

4. Providers of in-home care: Providers of in-home care, that is, care of a REACH/JOBS participant's children in the participant's own home, shall be evaluated using the "Self-Arranged Care Inspection and Interview Checklist", in order to qualify for payment through the REACH/JOBS program.

5. Providers of child care not in the categories (f)1 through 4 above are not entitled to payment through the REACH/JOBS program for child care provided to children of REACH/JOBS participants.

(g) Payment procedures: REACH/JOBS funds are expended for child care as direct vendor payments to providers or as direct payments to participants.

1. Vendor payments: Vendor payments to providers are the primary method for issuing child care payments in REACH/JOBS. Under this method, a voucher is issued to the child care provider. The provider completes the voucher, indicates appropriate attendance code for the child and payment required, and returns it to the agency responsible for issuing payment. Upon verification of the voucher information, the agency issues a REACH/JOBS child care payment to the provider.

2. (No change.)

3. Special payments for child care: Payments for child care at other than the standard payment rates may be made for special circumstances such as, emergency needs, drop-in care and approved interim care, as deemed appropriate by the case manager.

4.-6. (No change.)

(h)-(j) (No change.)

10:81-14.19 REACH/JOBS supportive services: participant allowances (PALS) for transportation and work/training-related expenses

(a)-(d) (No change.)

(e) $100.00 cumulative allowance to accept or maintain employment (JOB): Allowance payments (JOBs) based on need, up to a maximum cumulative total of $100.00 per eligibility participation period (see (g) below), are provided for actual expenses necessary to permit an individual to accept or maintain employment. Such payments shall be issued in preparation for and during the course

of employment. JOB payments are not an entitlement and are issued based on need only for actual expenses incurred.

1.-4. (No change.)

5. Each eligibility participation period covered by the cumulative $100.00 JOB fund begins with the first day the participant receives a firm job offer and accepts the position (the effective date of employment indicated on the OMEGA System) and ends 90 days after loss of eligibility for AFDC cash assistance. Therefore, employed individuals receiving post-AFDC child care and/or Medicaid, if determined in need of monies available through the JOB allowance, shall be authorized for payment of that allowance or of the remaining portion of that allowance fund only for the first 90 days following the AFDC case closing. The eligibility participation period for WSP and OJT participants begins with the effective date of the activity, as indicated on the OMEGA system, and ends no later than 90 days after loss of eligibility for cash assistance or the expiration of the OJT contract, whichever occurs first.

i. Example: If an AFDC individual enters a six month OJT or WSP activity in January and loses AFDC eligibility effective March 1, he or she would remain eligible for the JOB allowance through May 29 in the post-AFDC period which encompasses the 90-day limited timeframe for Federal financial participation (FFP). Although there are four months remaining in the activity contract period through June, the final month of participation in the activity, no authorization for participant allowances can be made for that final month.

6.-7. (No change.)

(f) REACH/JOBS $500.00 cumulative motor vehicle related (CAR) expense allowance: Allowance payments based on need, up to a maximum cumulative total of $500.00 per eligibility participation period (see (g) below), are available for REACH/JOBS participants who own motor vehicles to make those vehicles operational to transport the REACH/JOBS participant to REACH/JOBS activities or employment. CAR allowances are not an entitlement and are issued based on need, only for actual expenses incurred. CAR allowance payments are available beginning with participation in the first REACH/JOBS activity (the effective date of the activity as indicated on the OMEGA System) and ending no later than 90 days after loss of eligibility for AFDC in the post-AFDC period.

1. Example: A former AFDC REACH/JOBS participant has been employed and is in receipt of post-AFDC child care services. The AFDC case closed as of August 1. On November 15, the recipient requests a CAR allowance of $50.00. In this instance, case management cannot authorize payment from the CAR allowance fund since the 90-day authorization period has expired.

Recodify existing 1 through 6 as 2 through 7 (No change in text.)

(g)-(j) (No change.)

APPENDIX A
SELF-ARRANGED CARE INSPECTION
AND INTERVIEW CHECKLIST

(No change in text.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Assistance Standards Handbook
Aid to Families with Dependent Children (AFDC)
Readoption with Amendments: N.J.A.C. 10:82

Proposed: April 18, 1994 at 26 N.J.R. 1584(a).

Adopted: July 20, 1994 by William Waldman, Commissioner, Department of Human Services.

Filed: July 25, 1994 as R.1994 d.430, **without change.**

Authority: N.J.S.A. 44:10-3, 58 CFR 49218, 45 CFR 233.30 and Federal Action Transmittal Act ACF-AT-93-17.

Effective Date: July 25, 1994, Readoption;
August 15, 1994, Amendments.

Expiration Date: July 25, 1999.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:82.

Full text of the adopted amendments follows:

10:82-1.9 School attendance defined

(a) A child eligible under the age requirement of N.J.A.C. 10:81-3.13(a) shall be considered a student regularly attending a school or training course when he or she is enrolled in and physically attending, as certified by the school or institute, a program of study or training leading to a certificate, diploma or degree:

1.-2. (No change.)

2. At least half time and is precluded from full-time attendance or part-time employment because of a verified physical disability.

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

10:82-2.9 AFDC-C procedures for stepparents who have married an AFDC recipient parent prior to October 1, 1992, who marries on or after October 1, 1992 but prior to application or reapplication for AFDC, or who is a needy stepparent who marries an AFDC-C recipient on or after October 1, 1992

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

(d) When a stepparent of eligible AFDC-C children lives in the same home as the children, has married the AFDC-C recipient before October 1, 1992, or who marries the natural or adoptive parent on or after October 1, 1992 but prior to application or reapplication for AFDC benefits, and is not included as a member of the eligible family, his or her income shall be considered available to the eligible family in accordance with the following procedures:

1. Reduce the stepparent's gross earned income (and net income from self-employment) by $90.00.

2.-6. (No change.)

10:82-2.11 Medicaid eligibility; AFDC-C and -F procedures

(a) AFDC-C and -F parents (including parent-minors) who refuse to participate or accept employment under the REACH/JOBS or FDP programs are not entitled to categorically-related Medicaid. However, in New Jersey, the individual remains eligible for Medicaid so long as other Medicaid eligibility criteria are met.

(b)-(g) (No change.)

10:82-3.2 Exempt resources

(a) (No change.)

(b) The exempt resources are as follows:

1.-2. (No change.)

3. One motor vehicle, the equity value of which does not exceed $1,500. Any excess equity value of a motor vehicle and the full equity of any other motor vehicle is countable toward the $1,000 resource limit. If the vehicle is especially equipped with apparatus for the disabled, the apparatus shall not increase the value of the vehicle. The equity value of a vehicle shall be the average wholesale value as indicated in the most recent April or October edition of the Red Book; Official Used Car Valuations, less encumbrances (legal debts).

i. (No change.)

4.-5. (No change.)

6. Resources designated for special purposes as follows:

i.-vii. (No change.)

viii. Certain other Federal programs: Funds received by applicants and recipients through certain Federal programs (see (b)6vii(1) through (9) below) shall be regarded as exempt resources in determining eligibility for assistance.

(1)-(6) (No change.)

(7) Payments made through the United States Department of Housing and Urban Development (HUD) Section 8, Rental Assistance Program (RAP), which provides funds to certain disabled individuals and low income families to assist them in meeting shelter costs;

(8)-(9) (No change.)

ix. Stipends received by individuals who participate in the New Jersey Youth Corps Stipends Program shall be treated as an exempt

resource and not counted in the determination of AFDC eligibility nor in the calculation of grant entitlement.

7.-11. (No change.)

10:82-3.14 Deeming income of parents and guardians of adolescent parents

(a) (No change.)

(b) When an adolescent parent lives in the same home as his or her own parent(s), the income of such parent(s) shall be considered available to the eligible family in accordance with the following procedures. These rules do not apply if the parent(s) receive(s) SSI or AFDC or if the adolescent parent is categorically eligible for the -N segment only.

1.-6. (No change.)

(c) (No change.)

10:82-4.14 Exempt income

(a) (No change.)

(b) Exempt income is as follows:

1. (No change.)

2. Income tax refunds, including Homestead Property Tax Rebates; however, any portion of the actual refund remaining in the month following the month of receipt shall be considered as a resource in that following month.

3. EIC payments are to be considered excluded resources in the month of receipt and the month following the month of receipt.

i. The EIC is not considered a countable income source in the calculation of AFDC benefits (for all segments -C, -F, and -N).

10:82-5.3 Payment for child care through Title IV-A funds

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

(d) Family day care provider rules are:

1.-3. (No change.)

4. When it is essential for physical health and safety, the cost of transporting a disabled child to and from the family day care home may be authorized (see N.J.A.C. 10:82-5.2(e)2).

(e)-(h) (No change.)

10:82-5.10 Emergency assistance

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

(f) The county welfare agency shall authorize payment of the actual cost of adequate emergency shelter/housing arrangements at the most reasonable rate available, taking into consideration family circumstances and services provided, for three calendar months inclusive of the month in which EA benefits are first provided. If at the end of the third month for which EA has been provided permanent housing has not been secured, EA extensions may be authorized, if necessary, for up to two additional months. Such emergency shelter/housing, wherever possible, shall be in the municipality in which the eligible family currently resides. If, however, shelter/housing is not available at the most reasonable rate, taking into consideration family circumstances and services provided, within the municipality of customary residence, the recipient, as a condition of eligibility, shall be obliged to accept shelter/housing which is situated outside the municipality of customary residence. In situations where the county welfare agency determines that despite efforts of both the family and agency, permanent living arrangements are unavailable, an extension of emergency assistance may be authorized in accordance with the provisions of (f)1iii below.

1. (No change.)

2. Payment may be authorized for up to any three calendar months of retroactive rental or mortgage payments and/or six calendar months of retroactive utility payments if it will prevent actual eviction or foreclosure.

i. (No change.)

ii. Basic utilities are those that are necessary to make a dwelling habitable. At a minimum, basic utilities shall include electric, water, a fuel source for heating and cooking and, where applicable, sewerage and garbage disposal. In those instances where it is necessary to pay a utility deposit in order to reinstate utilities, such payment is acceptable under EA.

3.-6. (No change.)

(g)-(i) (No change.)

(j) Emergency house furnishings allowance: Allowances for those items deemed urgent and essential to the physical health and safety of the eligible unit shall not exceed the maximums listed below.

1. (No change.)

2. Replacement of house furnishings is not solely limited to replacement of items lost or destroyed in the incident that gave rise to the emergency. For example, a family may be moving from a hotel/motel shelter or furnished apartment into an unfurnished living arrangement and they do not possess essential furniture. Another example of when the use of EA funds is appropriate for replacement purposes is when an item such as a refrigerator may wear out which, because of the nature of the item, is essential for the health and well-being of the family.

(k)-(m) (No change.)

(n) Whenever a family requiring the provision of EA benefits moves from one county to another, the following provisions shall apply:

1.-2. (No change.)

3. When a non-EA AFDC recipient family voluntarily moves from one county to another, with or without CWA intercession, and a subsequent change in circumstances results in the need for EA, the new county of residence shall immediately assume responsibility for EA payments, as well as all other case management functions, pursuant to case transfer provisions at N.J.A.C. 10:81-3.27.

4. (No change.)

EMERGENCY ADOPTION

HUMAN SERVICES

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Manual for Hospital Services

Charity Care Component of the Health Care Subsidy Fund

Adopted Joint Emergency Amendment and Concurrent Proposed Amendment: N.J.A.C. 10:52-8.2

Emergency Amendment Adopted and Concurrent Proposed Amendment Authorized: July 28, 1994 by William Waldman, Commissioner, Department of Human Services, and approved by the Essential Health Services Commission, Victoria Wicks, Chair.

Filed: August 1, 1994 as R.1994 d.440.

Gubernatorial Approval (N.J.S.A. 52:14B-4(c)): August 1, 1994.

Authority: N.J.S.A. 30:4D-5; 6a(1); 7, 7a, b, c, and e; and 12; 1902(a)(13) of the Social Security Act; 42 U.S.C. 1396a(a)(13): 42 CFR 447.250; N.J.S.A. 26:2H-18.56g.

Proposal Number: PRN 1994-476.

Agency Control Number: 94-ER-33.

Emergency Amendment Effective Date: August 1, 1994.

Emergency Amendment Expiration Date: September 30, 1994.

Submit comments by September 14, 1994 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN 712
Trenton, New Jersey 08625-0712

and

Anne Weiss, Executive Director
Essential Health Services Commission
CN 360
Trenton, New Jersey 08625-0360

This is a joint emergency amendment and concurrent proposed amendment promulgated by the Department of Human Services/Division of Medical Assistance and Health Services and the Essential Health Services Commission (EHSC). This amendment was adopted on an emergency basis and became effective upon acceptance for filing by the Office of Administrative Law (see N.J.S.A. 52:14B-4(C) as implemented by N.J.A.C. 1:30-4.4). Concurrently, the provisions of this emergency amendment are being proposed for readoption in compliance with the normal rulemaking requirements of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. The readopted rule becomes effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), if filed on or prior to the emergency expiration date.

The agency and the EHSC's emergency amendment and concurrent proposal are as follows:

Summary

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services, jointly and under the direction of the Essential Health Services Commission (the Commission), is proposing the following amendment which will govern distribution of the charity care component of the disproportionate share subsidy required by the Health Care Reform Act of 1992 (P.L. 1992, c.160) (referred to herein as Chapter 160).

P.L. 1992, c.160 requires the Essential Health Services Commission to establish a claims processing system for the charity care component of the Medicaid disproportionate share subsidy. Under Chapter 160, if a charity care claims processing system was not in effect as of January 1, 1994, the Commission is required to make payments through the Medicaid program based on the charity costs incurred by hospitals in 1993. The Commission is in the process of establishing a claims system which is expected to be put in place by 1995. Under this proposed amendment, since no claims processing system currently exists, annual charity care costs incurred by hospitals will be the basis of payment of charity care subsidies. The determination of annual charity care costs will be based on data from the New Jersey Department of Health's audit of charity care provided by all hospitals. The Department of Health has conducted an audit of hospitals' charity care in accordance with N.J.A.C. 8:31B-4.41A through 4.41N. However for purposes of the 1993 charity care allocation, the criteria in 8:31B-41D through 41L did not apply to patients who are investigated by a county adjuster and found to be indigent by a court of competent jurisdiction; and, hospitals may document that the applicant was a New Jersey resident by either the criteria in N.J.A.C. 8:31B-4.37(d)7, or that in N.J.A.C. 8:31B-4.41F.

The Commission has chosen to adopt the Department of Health (DOH) audit of 1993 charity care as its measure of the charity care costs incurred by hospitals in 1993, because it is the most consistent, comprehensive source of information available. The Department of Health (DOH) has audited the hospital charity care since 1989 in carrying out its responsibilities under the hospital rate setting system. Chapter 160 required the DOH to conduct an audit in 1993. The DOH issued proposed rules governing the audit in August 1993. These rules were adopted in October of 1993. The audit regulations were substantially unchanged except that they broadened the categories of eligibility and acceptable proof of eligibility. Therefore, the process in place for complying with this audit was known to hospitals, and was not disruptive.

There is no other consistent source of information on the costs of charity care. Standard accounting practice is to value charity care at a hospital's charges, analogous to the "list price." Hospitals may set very different prices for the same procedures, and charges often are not reflective of the cost of the service. Medicaid's valuation of these accounts is a consistent source of information, and is also required by Chapter 160.

Pending the completion of this audit, the Commission had directed Medicaid to make provisional payments to hospitals at 90 percent of 1993 charity care subsidy levels defined under N.J.A.C. 10:52-8.1.

The proposed amendment describes the methodology for determining final approved subsidy amounts based on an audit. Under the New Jersey Department of Health (DOH) audit, hospitals submit their lists of charity care accounts per N.J.A.C. 8:31B-4.41A, and report the write-off amounts as charges. Because Chapter 160 requires charity care to be paid at Medicaid rates, for the purposes of the Commission's charity care allocations, the New Jersey Department of Health (DOH) and the New Jersey Department of Human Services (DHS) then value the accounts at the Medicaid rate to provide a standardized basis for measuring charity care costs. For the valuation of inpatient accounts, hospitals submit all accounts to DOH in a specific format; the DHS then values these accounts at the Medicaid rates. For outpatient accounts, hospitals submit the total dollar value of all prior year charity care outpatient accounts to DOH. The DOH applies each hospital's ratio of Medicaid payments to charges to the hospital's total outpatient charity care charges.

Under P.L. 1992, chapter 160, 80 percent of hospitals are eligible to receive a 1994 subsidy. Eligibility is determined by ranking hospitals by the result of dividing the individual hospital's annual charity care dollar amount by the hospital's revenue cap as calculated under Chapter 160. In accordance with the intent of the Legislature, 80 percent of the hospitals with the highest rankings will be eligible for the 1994 subsidy.

For the eligible hospitals, charity care subsidy amounts are equal to charity care costs as determined by the audit and valued at Medicaid rates. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase used to set Medicaid hospitals rates will be used to inflate the charity care costs in the current year.

Social Impact

The proposed amendment will have an impact on the total charity care amount provided to all eligible hospitals. Hospitals which have demonstrated that they incur significant charity care costs will receive subsidy funds and will be able to continue to provide these services. The amendment determines hospitals' eligibility for charity care subsidies on the basis of the annual charity care costs as measured by a New Jersey Department of Health audit and valued at the Medicaid rates. Under this audit, costs can be written off as charity care only if the patient is documented to meet certain income and eligibility standards. These

include income (less than 300 percent of poverty), assets ($3,000 for an individual, $6,000 for a family, defined as liquid assets plus equity in a non-primary residence), New Jersey residency, and services that are ineligible for other third party coverage. The use of these audited costs assures that funds will be targeted to hospitals which service patients with the fewest financial resources. With the promulgation of this amendment, and in accordance with the Legislature's intent, the Essential Health Services Commission and the Division of Medical Assistance and Health Services are ensuring that those hospitals which are deserving of it will receive substantial funds from the State.

Although this amendment limits charity care subsidies to 80 percent of New Jersey acute care hospitals, various State and Federal authorities require that all hospitals provide access to care regardless of ability to pay.

Economic Impact

The proposed methodology will provide the largest proportion of charity care subsidy money to hospitals who incurred the greater costs for this component in 1993. This will assist disproportionate share hospitals in maintaining and/or expanding services to these populations.

Some hospitals will receive a decreased subsidy amount from that which they received in 1993 or received on an interim basis in 1994. These overpayments will be recovered by the Division against all Medicaid payments to the hospital.

An effect of this amendment will be that charity care subsidies received by most facilities will change.

Regulatory Flexibility Analysis

A regulatory flexibility analysis might not be necessary because most hospital providers are not considered small businesses under the terms as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The hospitals in New Jersey are the only businesses affected by the proposed amendment, and they all employ more than 100 full time people. However, in the event hospitals might qualify under the terms of the Act, this analysis is included.

Hospitals are required to maintain sufficient records to indicate the name of the patient, dates of service, nature and extent of inpatient hospital services, and any additional information as may be required by regulation. The requirement is part of the State Medicaid Statute, N.J.S.A. 30:4D-12. With respect to reimbursement, hospitals will be required to maintain sufficient records, such as cost studies, to enable the Division to establish rates under this regulation. The reporting provisions will be similar to the regulatory requirements that existed under N.J.A.C. 8:41B. These requirements apply uniformly to all providers. There is no differentiation in the reporting, recordkeeping or compliance requirements based on size. The proposed amendment does not create any additional reporting, recordkeeping or other compliance requirement. There should be no need to hire any additional professional staff other than those persons already involved in preparing cost reports and related reimbursement data.

There are no capital costs associated with this amendment.

Full text of the adopted emergency amendment and concurrent proposed amendment follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

10:52-8.2 Method of payment

(a) The disproportionate share adjustment shall include [at least] the adjustment amount [recommended] **annually determined** by the [Commissioner of the Department of Health] **Essential Health Services Commission** based upon a determination regarding payments for charity and uncompensated care from the Health Care Subsidy Fund.

1. For facilities operating under N.J.S.A. 18A:64G-1 et seq., the disproportionate share adjustment [recommended] **determined** by the [Commissioner of Health] **Essential Health Services Commission** may be increased by an amount recommended by the Office of Management and Budget which will consider the total operating cost of the facility less any third party payments, including all other Medicaid payments, as well as payments from non-State sources for services provided by the hospital during the hospital's fiscal year.

2. The recommendation from the [Department of Health] **Essential Health Services Commission** shall be calculated in the following manner pursuant to P.L. 1992, c.160 **(N.J.S.A. 26:2H-18)**.

[i. Charity Care component of the Hospital Health Care Subsidy Fund shall be calculated by ranking hospitals using the following formula:

Hospital Specific Approved Uncompensated Care 1991
Hospital Specific Preliminary Cost Base 1992
= Hospital Specific % Uncompensated Care (%UC).

ii. If a hospital's Uncompensated Care percentage (%UC) is among the 80% of hospitals with the highest percentage of uncompensated care, it is eligible to receive a Health Care Subsidy Fund Charity Care adjustment. This adjustment shall equal the product of the facility's hospital specific percentage of uncompensated care times the funds allocated to the Charity Care Component of the Health Care Subsidy Fund. The calculation of the hospital's uncompensated care shall be based upon the amount of uncompensated care reported in 1991 to the Department of Health and shall exclude Medicare bad debt, offsetting Indigency Grants/payments and Uncompensated Care for Excluded Health Services.]

i. The determination of the Charity Care Component Costs of the Health Care Subsidy Fund shall be calculated in the following manner:

(1) The Essential Health Services Commission shall use the results of the charity care audit conducted as its definition of charity care incurred by all hospitals.

(2) The New Jersey Department of Health shall report to the Essential Health Services Commission, the results of its audit of New Jersey acute care hospital's charity care provided in the year per N.J.A.C. 8:31B-4.41 through 4.41N.

(A) For purposes of determining annual charity care costs, hospitals shall submit their audit lists per N.J.A.C. 8:31B-4.41A but may list their accounts by charges rather than the Medicaid rate.

(B) For purposes of determining annual charity care costs, the criteria in N.J.A.C. 8:31B-4.41D through 4.41L shall not apply to a patient who is investigated by a county adjuster and found to be indigent by a court of competent jurisdiction pursuant to N.J.S.A. 30:4. A patient so found shall qualify for 100 percent charity care coverage. Hospitals with patients who qualify under this provision shall include the appropriate documentation from the court in the patient's file for audit.

(C) For purposes of determining annual charity care costs, hospitals may document New Jersey residency for patients in either of the following two ways: hospitals must document that the applicant was a New Jersey resident at the time he or she received services and had the intent to remain in the State. An out-of-State resident may apply for charity care if his or her services resulted from a situation requiring immediate medical care pursuant to N.J.A.C. 8:31B-4.41F.

(3) All charity care accounts shall be valued at the Medicaid rate as follows:

(A) For inpatient accounts, the New Jersey Department of Health and the New Jersey Department of Human Services shall value each account at the rate Medicaid would have reimbursed hospitals for the service(s).

(B) For outpatient accounts, outpatient charity care accounts written-off during the calendar year will be valued as follows: annual outpatient charity care charges multiplied by the ratio of the annual outpatient Medicaid payments to the annual outpatient Medicaid charges associated with paid claims. This Medicaid outpatient payment-to-charge ratio excludes billings for HealthStart and dental services.

(C) Disproportionate share adjustments and final rate settlements for the service period shall not be taken into account for the recognition of charity care costs.

(4) If a hospital's percentage of charity care costs in relation to their revenue cap is among the 80 percent of hospitals with the highest percentage of charity care, it is eligible to receive a Health Care Subsidy Fund Charity Care adjustment.

(5) For eligible hospitals, charity care subsidy amounts are determined as follows:

(A) Eligible hospitals annual charity care subsidy amount is equal to charity care costs as determined by the audit and valued at Medicaid rates.

(B) The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase used to set Medicaid hospital rates will be used to inflate charity care costs in the current year.

(C) In no instances shall payments made during a calendar year exceed the preceding years audited and Medicaid rate valued amounts inflated by TEFRA rates used in the hospital rate setting system.

(D) Any overpayments which result from interim payments exceeding the audited payment levels shall be recovered by offsetting all Medicaid payments.

Recodify existing iii.-v. as **ii.-iv.** (No change in text.)

Recodify existing (d)-(e) as **(b)-(c)** (No change in text.)

PUBLIC NOTICES

EDUCATION

(a)

STATE BOARD OF EDUCATION

Notice of Public Testimony Session September 21, 1994

Take notice that the following agenda item is scheduled for Notice of Proposal in the September 6, 1994 New Jersey Register and is, therefore, subject to public comment. Pursuant to the policy of the New Jersey State Board of Education, a public testimony session will be held for the purpose of receiving public comment on Wednesday, September 21, 1994 from 3:00 P.M. to 6:00 P.M. in the 8th Floor Training Room, Department of Education, 225 East State Street, Trenton, New Jersey.

To reserve time to speak call the State Board Office at (609) 292-0739 by 3:00 P.M. Friday, September 16, 1994.

Rule Proposal: N.J.A.C. 6:7, State-Operated School Districts

ENVIRONMENTAL PROTECTION

(b)

HAZARDOUS WASTE FACILITIES SITING COMMISSION

Notice of Public Hearings and Opportunity for Comment

Proposed 1994 Update to the New Jersey Hazardous Waste Facilities Plan

Authorized By: Hazardous Waste Facilities Siting Commission, Louis R. Matlack, Chairman.

Authority: Major Hazardous Waste Facilities Siting Act, N.J.S.A. 13:1E-49 et seq.

Take notice that three **public hearings** on the proposed 1994 update to the New Jersey Hazardous Waste Facilities Plan will be held on September 19th, 20th, and 21st, 1994 at three locations in New Jersey (Central, South and North), as described below:

Central
Monday, September 19, 1994
7 P.M. to 9 P.M.
New Jersey State Museum, 2nd Floor
205 West State Street
Trenton, New Jersey

South
Tuesday, September 20, 1994
7 P.M. to 9 P.M.
Gloucester Township Municipal Building
Council Room, 1st Floor
1261 Shews Landing Road
Laurel Springs, New Jersey

North
Wednesday, September 21, 1994
7 P.M. to 9 P.M.
McManus Junior High School
Edgewood Road
Linden, New Jersey

The **purpose** of these public hearings will be to solicit public comment on the contents of this proposed Plan Update. Individuals wishing to speak at any of the public hearings can preregister by calling the Commission office (609-292-1459). **Submit written comments** at any of the public hearings or by September 26th, 1994 to:

Joseph E. Gilson, Jr., Executive Director
Hazardous Waste Facilities Siting Commission
CN-406
Trenton, New Jersey 08625

Take further notice that the Major Hazardous Waste Facilities Siting Act, at N.J.S.A. 13:1E-58, requires this Commission to prepare and adopt, in consultation with the Hazardous Waste Advisory Council, a Major Hazardous Waste Facilities Plan. The Commission is seeking public comment on this proposed Plan Update. The Plan Update will be available for public review at the Commission office, 28 West State Street, Trenton, New Jersey; the New Jersey State Library, 185 West State St., Trenton, New Jersey; and at county libraries.

The proposed Plan Update addresses the following areas: (a) an inventory and appraisal, including the identity and location of all hazardous waste facilities within the State; (b) an inventory of the sources, composition, and quantity of hazardous waste generated within the State; (c) projections of the quantities of hazardous waste to be generated within the State for a three year period of time; (d) identification of the types of new hazardous waste facilities which could reduce New Jersey's dependence on out-of-State facilities; and (e) identification of the importance of New Jersey hazardous waste facilities to out-of-State generators and also the importance of out-of-State facilities for New Jersey's hazardous waste treatment and disposal needs.

This proposed Plan Update identifies the greatest capacity shortfall for in-State landfill disposal capacity, which is consistent with the findings in the 1985 Plan and 1989 Plan Update. Because of New Jersey geology and the strict siting criteria, the Plan Update concludes that it will be very difficult to site a land disposal facility in New Jersey. This was shown by the Commission's four year effort to site a private commercial above ground land emplacement facility. The Commission dropped four potential land emplacement facilities due to their inability to meet the State's siting criteria. Therefore, New Jersey should commence discussions with other states to establish interstate and regional agreements to satisfy its capacity shortfalls. States that are important for New Jersey land disposal needs include New York, Ohio, South Carolina, Michigan, and Indiana. Three private landfills in New York, Ohio and South Carolina received 255,311 tons (or 82 percent) of the New Jersey hazardous waste exported to landfills in 1992.

In the 1989 Plan Update, the need for increased incinerator capacity was primarily driven by anticipated Best Demonstrated Available Technologies (BDAT), Land Ban disposal restrictions, and other expected changes in Federal regulations. The Land Ban and BDAT regulations were expected to transfer wastes from landfill disposal to incineration. The 1989 Plan Update did not anticipate the extent to which cement kilns would enter the hazardous waste market and increase their demand for hazardous waste as an alternate fuel. Actual incinerator demand since the 1989 Plan Update has increased only marginally, apparently because of the increased use of hazardous waste as fuel by cement kilns.

While New Jersey continues to ship hazardous waste to both in-State and out-of-State incinerators, the shortfall for in-State incinerator capacity may increase in the future if cement kilns cannot meet new U.S. Environmental Protection Agency Boiler and Industrial Furnace (BIF) regulations and emission requirements, or if the Bevill Amendment to the Resource Conservation and Recovery Act (RCRA) is eliminated, that is, if cement kiln dust is reclassified as hazardous. This would shift current hazardous waste shipments from cement kilns and increase the demand for incinerators. In addition, increased compliance costs for cement kilns resulting from stricter Federal and/or State regulations will likely increase the disposal fees at cement kilns. Increased disposal fees will decrease the competitive price advantage currently enjoyed by cement kilns over incinerators.

In summary, the Commission supports the expansion of existing hazardous waste treatment, storage, and disposal (TSD) facilities and/or the in-State siting of new hazardous waste facilities if such facilities can lessen New Jersey's dependence on out-of-State TSDs, including hazardous waste exports to out-of-State incinerators, landfills, and cement kilns. The Commission, therefore, reaffirms the findings of the 1985 Plan and the 1989 Plan Update, identifying the types of new facilities which could reduce New Jersey's capacity shortfalls, namely:

a) An 80 acre above ground land emplacement facility with a capacity of 110,000 to 120,000 tons per year and a 20 year life (Chapter 1, page 5, 1989 Plan Update), and

b) An incinerator of rotary kiln technology because of its commercially proven history and its versatility in managing a wide range of hazardous waste (Chapter 1, page 5, 1989 Plan Update).

However, in addition to meeting the strict siting criteria, any new facility must be operated in accordance with the Siting Act. In addition, New Jersey should examine the efficacy of entering into long term

interstate capacity sharing agreements with its major export-import partners.

The dynamic changes occurring in hazardous waste treatment and disposal, both on a State and national basis, make the issuance of annual Plan Updates imperative. Waiting for the Federal Capacity Assurance Plan and the three year update from the Commission needlessly handicaps good planning. The improvement in the Commission's data processing capability permits reliable analyses of hazardous waste information and the publication of a Plan Update by the second quarter of the succeeding year. This promptness and precision will encourage the continual monitoring and evaluating of hazardous waste management in New Jersey. Moreover, this will enable the Commission to estimate the effects of changing regulations early enough to provide meaningful assistance to the hazardous waste planning process in New Jersey.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Mercer County Water Quality Management Plan

Public Notice

Take notice that on June 30, 1994, pursuant to the provisions of the New Jersey Water Quality Planning Act, N.J.S.A. 58:11A-1 et seq., and the Statewide Water Quality Management Planning rules (N.J.A.C. 7:15-3.4), an amendment to the Mercer County Water Quality Management Plan was adopted by the Department. This amendment will change the Stony Brook Regional Sewerage Authority's (SBRSA) sewer service area in two areas of Princeton Township: (1) flows in the North Ridge Area of Princeton Township presently served by the Montgomery Stage II Sewage Treatment Plant (STP) will be re-directed to the SBRSA STP; and (2) realignment of the SBRSA sewer service area within the lands of the Institute of Advanced Study (identified as Block S-12.04, Lots 110, 134, and 136, zoning district R-HF-W sub-area A on the August 1993, Princeton & Princeton Borough Sewer Service Area Delineation Map 4) to comply with recent zoning changes. Additionally, the amendment updates the Princeton Township/Princeton Borough Wastewater Management Plan regarding abandonment of the Pretty Brook STP and its conversion to a pump station.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

(b)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Tri-County Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection (NJDEP) is seeking public comments on a proposed amendment to the Tri-County Water Quality Management (WQM) Plan. This amendment proposal was submitted by Irick Engineering on behalf of Volunteers of America—Delaware Valley Property, Inc. The amendment would update the Elk Township Wastewater Management Plan by identifying the Carpenter's House site as an area to be served by subsurface sewage disposal system(s) less than 20,000 gallons per day. Carpenter's House is an existing residential structure located on the west side of Aura—Glassboro Road, being Lot 3, Block 67 in Elk Township, Gloucester County. An expansion to the existing structure has been proposed to house an additional 12 residents and 4 staff. To accommodate the additional wastewater, the existing on-site septic system will be repaired and a new septic system will be installed to service the new addition. The project site lies within a proposed future sewer service area of the Gloucester County Utilities Authority's (GCUA) West Deptford Sewage Treatment Plant (STP). Should service to GCUA's STP become available in the future, Carpenter's House would be required to connect in.

This amendment represents only one part of the permit process and other issues will be addressed prior to final permit issuance. Additional issues which were not reviewed in conjunction with this amendment but which may need to be addressed may include, but are not limited to, the following: antidegradation; effluent limitations; water quality analysis; exact locations and designs of future treatment works (pump stations, interceptors, sewers, outfalls, wastewater treatment plants); and development in wetlands, flood prone areas, designated Wild and Scenic River areas, or other environmentally sensitive areas which are subject to regulation under Federal or State statutes or rules.

This notice is being given to inform the public that a plan amendment has been proposed for the Tri-County WQM Plan. All information related to the WQM Plan, and the proposed amendment is located at the NJDEP, Office of Land and Water Planning, CN423, 401 East State Street, Trenton, N.J. 08625. It is available for inspection between 8:30 A.M. and 4:00 P.M., Monday through Friday. An appointment to inspect the documents may be arranged by calling the Office of Land and Water Planning at (609) 633-1179.

Interested persons should submit written comments on the proposed amendment to Dr. Daniel J. Van Abs, at the NJDEP address cited above with a copy sent to Catherine Ward, Esq., Jubanyik, Varbalow, Tedesco, Shaw and Shaffer, 1701 Route 70 East, P.O. Box 2570, Cherry Hill, N.J. 08034. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by NJDEP with respect to the amendment request.

Any interested persons may request in writing that NJDEP hold a nonadversarial public hearing on the amendment (or extend the public comment period in this notice up to 30 additional days). These requests must state the nature of the issues to be raised at the proposed hearing or state the reasons why the proposed extension is necessary. These requests must be submitted within 30 days of the date of this notice to Dr. Van Abs at the NJDEP address cited above. If a public hearing for the amendment is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

HUMAN SERVICES

(c)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
ESSENTIAL HEALTH SERVICES COMMISSION

Notice of Receipt of Petition for Rulemaking
P.L. 1992, c.160, commonly referred to as the Health Care Reform Act of 1992

Petitioner: Members of the Hospital Alliance of New Jersey and Hackensack Medical Center, as represented by Sills, Cummis, Zuckerman, Radin, Tischman, Epstein & Gross.

Take notice that on July 11, 1994, the New Jersey Department of Human Services and the Essential Health Services Commission, received a petition for rulemaking concerning the charity care subsidy contained in P.L. 1992, c.160, commonly referred to as the Health Care Reform Act of 1992.

Petitioners comprise several hospitals that provide hospital services to New Jersey Medicaid patients.

Petitioner requests that neither the Essential Health Services Commission nor the Department of Human Services take any formal action regarding the disbursement of charity care until regulations are issued. Petitioner also requests formal rulemaking on exactly how the Essential Health Services Commission will measure charity care costs incurred in 1993 and exactly how it will base the distribution of the charity care in 1994 on that measurement.

In accordance with the provisions of N.J.A.C. 1:30-3.6, the Department/Division, or the Essential Health Care Services Commission, shall subsequently mail to the petitioner, and file with the Office of Administrative Law, a notice of action on the petition.

(a)

DIVISION OF FAMILY DEVELOPMENT

Child Care Development and Block Grant (CCDBG)

N.J.A.C. 10:15-1.1(d)

Notice of Public Hearing

Take notice that regional public hearings concerning the New Jersey Child Care Development and Block Grant State Plan will be held in accordance with N.J.A.C. 10:15-1.1(d) on September 13, 20 and 27, 1994. These hearings are being cosponsored by the New Jersey Department of Human Services, Division of Family Development, Division of Youth and Family Services, Division on Women, National Association for the Education of Young Children, New Jersey Association for the Education of Young Children, New Jersey Child Care Advisory Council, Association for Children of New Jersey, Family Day Care Organization of New Jersey, New Jersey School-Age Child Care Coalition, New Jersey Black Child Development Institute, New Jersey Association of Child Care Resource and Referral Agencies, New Jersey League of Women Voters and the New Jersey Statewide Coalition of Child Care.

The **public hearings** will be held from 3:30 to 6:30 P.M. as follows:

Tuesday, September 13, 1994 (Central Region)
Rutgers University—Busch Campus
New Brunswick, New Jersey

Tuesday, September 20, 1994 (Northern Region)
Morris County Arboretum
Morristown, New Jersey

Tuesday, September 27 (Southern Region)
Educational Information and Resource Center
Sewell, New Jersey

Individuals interested in testifying at the hearings should advise the Department of Human Services, Trenton, New Jersey by telephone at (609) 984-0879, or by facsimile at (609) 984-7380, prior to the scheduled hearing date and must provide name(s), organization represented and telephone number. Individuals interested in testifying may also register at the hearing site and will be permitted to testify, as time permits. Interested speakers will be limited to three minutes of oral testimony.

All facilities are barrier free. Should anyone need or be aware of any individual(s) wishing to attend the above hearing(s) who may require accommodation due to a disability, please contact Dr. Edna Ranck, at (609) 984-0879, to make arrangements.

Interested parties must submit four copies of written testimony at the hearing, or by mail until October 7, 1994. The written testimony should be mailed to:

Dr. Edna Ranck, Child Care Coordinator
Department of Human Services
CN 700
Trenton, New Jersey 08625

REGISTER INDEX OF RULE PROPOSALS AND ADOPTIONS

The research supplement to the New Jersey Administrative Code

A CUMULATIVE LISTING OF CURRENT PROPOSALS AND ADOPTIONS

The **Register Index of Rule Proposals and Adoptions** is a complete listing of all active rule proposals (with the exception of rule changes proposed in this Register) and all new rules and amendments promulgated since the most recent update to the Administrative Code. Rule proposals in this issue will be entered in the Index of the next issue of the Register. **Adoptions promulgated in this Register have already been noted in the Index by the addition of the Document Number and Adoption Notice N.J.R. Citation next to the appropriate proposal listing.**

Generally, the key to locating a particular rule change is to find, under the appropriate Administrative Code Title, the N.J.A.C. citation of the rule you are researching. If you do not know the exact citation, scan the column of rule descriptions for the subject of your research. To be sure that you have found all of the changes, either proposed or adopted, to a given rule, scan the citations above and below that rule to find any related entries.

At the bottom of the index listing for each Administrative Code Title is the Transmittal number and date of the latest looseleaf update to that Title. Updates are issued monthly and include the previous month's adoptions, which are subsequently deleted from the Index. To be certain that you have a copy of all recent promulgations not yet issued in a Code update, retain each Register beginning with the July 5, 1994 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1994 d.1 means the first rule filed for 1994.

Adoption Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of an adopted amendment or new rule.

Transmittal. A series number and supplement date certifying the currency of rules found in each Title of the New Jersey Administrative Code: Rule adoptions published in the Register after the Transmittal date indicated do not yet appear in the loose-leaf volumes of the Code.

N.J.R. Citation Locator. An issue-by-issue listing of first and last pages of the previous 12 months of Registers. Use the locator to find the issue of publication of a rule proposal or adoption.

MOST RECENT UPDATE TO THE ADMINISTRATIVE CODE: SUPPLEMENT JUNE 20, 1994

NEXT UPDATE: SUPPLEMENT JULY 18, 1994

Note: If no changes have occurred in a Title during the previous month, no update will be issued for that Title.

N.J.R. CITATION LOCATOR

If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register	If the N.J.R. citation is between:	Then the rule proposal or adoption appears in this issue of the Register
25 N.J.R. 3583 and 3884	August 16, 1993	26 N.J.R. 1179 and 1272	March 7, 1994
25 N.J.R. 3885 and 4360	September 7, 1993	26 N.J.R. 1273 and 1416	March 21, 1994
25 N.J.R. 4361 and 4540	September 20, 1993	26 N.J.R. 1417 and 1554	April 4, 1994
25 N.J.R. 4541 and 4694	October 4, 1993	26 N.J.R. 1555 and 1738	April 18, 1994
25 N.J.R. 4695 and 4812	October 18, 1993	26 N.J.R. 1739 and 1904	May 2, 1994
25 N.J.R. 4813 and 4980	November 1, 1993	26 N.J.R. 1905 and 2166	May 16, 1994
25 N.J.R. 4981 and 5382	November 15, 1993	26 N.J.R. 2167 and 2510	June 6, 1994
25 N.J.R. 5383 and 5728	December 6, 1993	26 N.J.R. 2511 and 2692	June 20, 1994
25 N.J.R. 5729 and 6084	December 20, 1993	26 N.J.R. 2693 and 2828	July 5, 1994
26 N.J.R. 1 and 280	January 3, 1994	26 N.J.R. 2829 and 3102	July 18, 1994
26 N.J.R. 281 and 520	January 18, 1994	26 N.J.R. 3103 and 3230	August 1, 1994
26 N.J.R. 521 and 878	February 7, 1994	26 N.J.R. 3231 and 3504	August 15, 1994
26 N.J.R. 879 and 1178	February 22, 1994		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:10-1.1, 14.2, 14.3	Family Development hearings: reproposal	26 N.J.R. 1744(b)	R.1994 d.417	26 N.J.R. 3441(a)
1:12	Department of Labor hearings	26 N.J.R. 2174(a)	R.1994 d.406	26 N.J.R. 3154(a)
1:12A	Department of Labor hearings	26 N.J.R. 2174(a)	R.1994 d.406	26 N.J.R. 3154(a)
1:14-10	BRC ratemaking hearings: discovery	26 N.J.R. 3(a)		
1:14-10	BRC ratemaking hearings: extension of comment period regarding discovery process	26 N.J.R. 883(a)		
1:14-10	Board of Regulatory Commissioners ratemaking hearings: discovery	26 N.J.R. 2513(a)		
	Most recent update to Title 1: TRANSMITTAL 1994-3 (supplement June 20, 1994)			
AGRICULTURE—TITLE 2				
2:3	Livestock and poultry importation	26 N.J.R. 1908(a)	R.1994 d.399	26 N.J.R. 3159(a)
2:5	Quarantines and embargoes on animals	26 N.J.R. 1908(b)		
2:6	Animal health: biologics for diagnostic or therapeutic purposes	25 N.J.R. 4985(a)		
2:33	Agricultural fairs	26 N.J.R. 285(a)		
2:71-2.2, 2.4, 2.5, 2.6	Jersey Fresh Quality Grading Program: cut flowers, fresh market tomatoes	26 N.J.R. 2831(a)		
2:76	Agriculture Development Committee	26 N.J.R. 1419(a)	R.1994 d.393	26 N.J.R. 3159(b)
2:76-6.11	Farmland Preservation Program: correction to proposal and extension of comment period regarding acquisition of development easements	25 N.J.R. 4697(a)		
	Most recent update to Title 2: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
BANKING—TITLE 3				
3:1-2.17, 2.25, 2.26	Closing of branch offices	26 N.J.R. 883(b)	R.1994 d.318	26 N.J.R. 2779(a)
3:1-4.5	Governmental unit deposit protection: public funds exceeding 75 percent of capital funds	26 N.J.R. 2832(a)		
3:1-6.6	Department examination charges	26 N.J.R. 1560(b)		
3:4-3	Banking institutions: sale of alternative investments	25 N.J.R. 5733(a)		
3:6-15.2	Disqualification of savings bank directors	25 N.J.R. 3586(b)	R.1994 d.397	26 N.J.R. 3163(a)
3:11	Investments	26 N.J.R. 1909(a)	R.1994 d.377	26 N.J.R. 2892(a)
3:11-7.11	Disqualification of bank directors	25 N.J.R. 3586(b)	R.1994 d.397	26 N.J.R. 3163(a)
3:13-5	Mutual holding companies	26 N.J.R. 1213(a)	R.1994 d.373	26 N.J.R. 2892(b)
3:22	Insurance premium finance companies	26 N.J.R. 2697(a)		
3:32-3	Mutual holding companies	26 N.J.R. 1213(a)	R.1994 d.373	26 N.J.R. 2892(b)
3:38-5.3	Mortgage referrals by real estate agents	26 N.J.R. 6(a)		
3:38-5.3	Mortgage referrals by real estate agents: extension of comment period	26 N.J.R. 884(a)		
3:41-12	Cemetery Board: service contractors and service contracts	26 N.J.R. 6(b)		
	Most recent update to Title 3: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)			

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
PERSONNEL—TITLE 4A				
4A:1-2.3	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:2-2.3	Sexual harassment; discrimination complaints	26 N.J.R. 1182(a)		
4A:2-3.1	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:3-3.1	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:3-4.6	Voluntary furlough program for State employees	26 N.J.R. 2179(a)		
4A:4-2.1	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:4-2.15, 5.2	Voluntary furlough program for State employees	26 N.J.R. 2179(a)		
4A:4-4.8	Non-selection of eligible in same rank	26 N.J.R. 2697(b)		
4A:6-1.1, 1.8, 1.10, 1.21A	Family and medical leave	26 N.J.R. 1183(b)		
4A:6-1.2, 1.3, 1.5, 1.23, 2.4	Voluntary furlough program for State employees	26 N.J.R. 2179(a)		
4A:6-4.2	Department use of Social Security numbers	26 N.J.R. 287(a)		
4A:7-1.3, 3.3	Sexual harassment; discrimination complaints	26 N.J.R. 1182(a)		
4A:8-2.1	Layoff rights	26 N.J.R. 2182(a)		
4A:8-2.4	Voluntary furlough program for State employees	26 N.J.R. 2179(a)		
	Most recent update to Title 4A: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
COMMUNITY AFFAIRS—TITLE 5				
5:15	Emergency shelters for the homeless	26 N.J.R. 1421(a)	R.1994 d.324	26 N.J.R. 2779(b)
5:18-2.12, 2.21, App. 3-A	Uniform Fire Code: cigarette lighters	26 N.J.R. 2182(b)		
5:23-1.4	Uniform Construction Code: administrative change	_____	_____	26 N.J.R. 2779(c)
5:23-2.5	Uniform Construction Code: increase in dwelling size	26 N.J.R. 1910(a)		
5:23-2.23, 4.20	UCC: testing of blackflow preventers	26 N.J.R. 1911(a)		
5:23-3.4, 3.20A	Indoor air quality subcode	25 N.J.R. 5918(a)		
5:23-3.14, 7	Uniform Construction Code: Barrier Free Subcode	26 N.J.R. 2698(a)		
5:23-4.4, 4.5, 4.5A, 4.12, 4.14, 4.18, 4.20	Uniform Construction Code: private on-site inspection agencies	25 N.J.R. 2162(a)	R.1994 d.323	26 N.J.R. 2780(a)
5:23-5.19	UCC: elevator inspector HHS requirements	26 N.J.R. 1912(a)		
5:23-8.10	Asbestos Hazard Abatement Subcode: asbestos safety technician	26 N.J.R. 2183(a)		
5:23-10.1, 10.3, 10.4	Radon Hazard Subcode: schools and residential buildings in tier one areas	26 N.J.R. 2704(a)		
5:25-2.5	New home warranties and builder registration: denial of registration	26 N.J.R. 1913(a)		
5:25A-1.3, 2.1, 2.5, 2.6	FRT plywood roof sheathing failures: alternative claim procedures	26 N.J.R. 2706(a)		
5:34-7.2, 7.5, 7.6, 7.8, 7.9	Local government finance: renewal of registration of Cooperative Purchasing System	26 N.J.R. 2707(a)		
5:37	Municipal, county and authority employees deferred compensation plans	26 N.J.R. 2708(a)		
5:80-3.2	Housing and Mortgage Finance Agency: return on equity for housing project sponsors	26 N.J.R. 1186(a)	R.1994 d.398	26 N.J.R. 3163(b)
5:80-5.10	Housing and Mortgage Finance Agency: prepayment of project mortgage	26 N.J.R. 1187(a)		
5:93-3.6, 5.6	New Jersey Council on Affordable Housing: reductions for substantial compliance; zoning for inclusionary development	26 N.J.R. 2514(a)		
	Most recent update to Title 5: TRANSMITTAL 1994-5 (supplement June 20, 1994)			
MILITARY AND VETERANS' AFFAIRS—TITLE 5A				
	Most recent update to Title 5A: TRANSMITTAL 1994-1 (supplement June 20, 1994)			
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6:5-2, App.	Department of Education: organizational rule	Exempt	R.1994 d.333	26 N.J.R. 2784(a)
6:21	Pupil transportation	26 N.J.R. 1997(a)	R.1994 d.404	26 N.J.R. 3164(a)
6:26	Intervention and referral services for general education pupils	26 N.J.R. 2004(a)	R.1994 d.403	26 N.J.R. 3170(a)
6:28-2.10, 3.6, 4.3	Special education	26 N.J.R. 1422(a)	R.1994 d.334	26 N.J.R. 2787(a)
6:30-2.1	Adult basic skills programs: professional staff certification	26 N.J.R. 2184(a)		
6:39	District evaluation	26 N.J.R. 1423(a)	R.1994 d.335	26 N.J.R. 2788(a)
6:70	Library network services	26 N.J.R. 2184(b)		
	Most recent update to Title 6: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
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7:0	Management of waste oil: request for public comment	26 N.J.R. 1466(a)		
7:1C-1.1, 1.2, 1.5	Ninety-day construction permits: fees	26 N.J.R. 787(a)	R.1994 d.337	26 N.J.R. 2789(a)
7:1C-1.1, 1.3, 1.5	Ninety-day construction permits: fees	26 N.J.R. 913(a)	R.1994 d.379	26 N.J.R. 2920(a)
7:1G	Worker and Community Right to Know	26 N.J.R. 123(a)	R.1994 d.349	26 N.J.R. 2930(a)

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7:1G-2.1, 3.1	Community Right to Know: EPA list of regulated substances for accidental release prevention; hazardous substance reporting threshold	26 N.J.R. 2833(a)		
7:4A	Historic Preservation Grant Program	26 N.J.R. 3105(a)		
7:5D	State Trails System	26 N.J.R. 1459(a)		
7:7	Coastal Permit Program	26 N.J.R. 918(a)	R.1994 d.378	26 N.J.R. 2934(a)
7:7	Coastal Permit Program: extension of comment period	26 N.J.R. 1561(a)		
7:7-8	Coastal Permit Program: enforcement	26 N.J.R. 1745(a)	R.1994 d.413	26 N.J.R. 3188(a)
7:7E	Coastal zone management	26 N.J.R. 943(a)	R.1994 d.380	26 N.J.R. 2990(a)
7:7E	Coastal zone management: public meetings and opportunity for comment on proposed revisions to planning and growth region policies	26 N.J.R. 1003(a)		
7:7E-3.43	Coastal zone management: administrative correction regarding special urban areas	26 N.J.R. 1561(b)		
7:7E-8.12	Coastal zone management: notice of clarification	26 N.J.R. 1561(c)		
7:9A	Individual subsurface sewage disposal systems	26 N.J.R. 2715(a)		
7:10	Safe Drinking Water Act rules	26 N.J.R. 2720(a)		
7:13	Flood hazard area control	26 N.J.R. 1009(a)		
7:13	Flood hazard area control	26 N.J.R. 1036(a)	R.1994 d.338	26 N.J.R. 2791(a)
7:13-7.1	Flood plain redelineation of Pascack and Fieldstone brooks in Montvale	26 N.J.R. 2834(a)		
7:14A	New Jersey Pollutant Discharge Elimination System	26 N.J.R. 1332(a)		
7:14A-2.15, 6.14, 6.17, 12.4	Contaminated site remediation: NJPDES permit program	26 N.J.R. 158(a)		
7:15	Statewide Water Quality Management Planning Rules: public meetings and opportunity for comment on draft amendments	26 N.J.R. 792(a)		
7:15	Statewide water quality management planning	26 N.J.R. 3106(a)		
7:24A	Dam Restoration and Inland Waters Projects Loan Program	26 N.J.R. 2228(a)		
7:25-4	Implementation of Wild Bird Act of 1991	26 N.J.R. 1040(a)		
7:25-5	1994-95 Game Code	26 N.J.R. 1913(b)	R.1994 d.412	26 N.J.R. 3193(a)
7:25-6	1995-96 Fish Code	26 N.J.R. 2835(a)		
7:25-6.5	Fish Code: administrative correction regarding trout fishing areas	———	———	26 N.J.R. 3082(a)
7:25-18.1	Flounder management	26 N.J.R. 1885(a)	R.1994 d.339	26 N.J.R. 2792(a)
7:25-18.1, 18.5	Directed conch fishery	26 N.J.R. 1931(a)		
7:25-24.7, 24.9	Leasing of Atlantic coast bottom for aquaculture	26 N.J.R. 3109(a)		
7:25A-1.2, 1.4, 1.9, 4.3	Oyster management	26 N.J.R. 1652(a)		
7:26-1.4	Hazardous waste transportation: informal meeting on draft "10-day in-transit holding rule"	26 N.J.R. 294(a)		
7:26-8.2, 8.14	Hazardous waste from specific sources: removal of K053 through K059 and K074 from list	26 N.J.R. 1464(a)	R.1994 d.411	26 N.J.R. 3211(a)
7:26C	Site Remediation Program: opportunity for comment on draft remedial priority system	25 N.J.R. 4551(c)		
7:27-1, 8, 18, 22	Air pollution control: facility operating permits	25 N.J.R. 3963(a)		
7:27-1, 8, 18, 21, 22	Air pollution control: extension of comment period regarding facility operating permits, emission statements, and penalties	25 N.J.R. 4836(a)		
7:27-1, 8, 18, 22	Air Operating Permits and Reconstruction Permits: public roundtable on proposed new rules and amendments	26 N.J.R. 793(a)		
7:27-15.4	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:27-16.1	Control and prohibition of air pollution by VOS	25 N.J.R. 6002(a)		
7:27-21.1–21.5, 21.8, 21.9, 21.10	Air pollution control: facility emission statements	25 N.J.R. 4033(a)		
7:27-25.1, 25.3	Oxygenated fuels program	26 N.J.R. 1148(a)		
7:27-25.1, 25.3, 25.8	Control and prohibition of air pollution by vehicular fuels	26 N.J.R. 1048(a)		
7:27-25.1, 25.3, 25.8	Redesignation of carbon monoxide nonattainment areas and amendments regarding oxygenated fuels: public hearing time change	26 N.J.R. 1336(a)		
7:27-26	Low Emission Vehicles Program	26 N.J.R. 1467(a)		
7:27-27	Control and prohibition of mercury emissions	26 N.J.R. 1050(a)		
7:27A-3.2, 3.5, 3.10	Air pollution control: administrative penalties and requests for adjudicatory hearings	25 N.J.R. 4045(a)		
7:27A-3.10	Air pollution control: facility emission statement penalties	25 N.J.R. 4033(a)		
7:27A-3.10	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:27A-3.10	Control and prohibition of air pollution by VOS	25 N.J.R. 6002(a)		
7:27A-3.10	Control and prohibition of mercury emissions	26 N.J.R. 1050(a)		

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7:27B-4.5, 4.6, 4.9	Air quality management: enhanced Inspection and Maintenance program	25 N.J.R. 5130(a)		
7:28-48	Non-ionizing radiation producing sources: registration fees	25 N.J.R. 5422(a)		
7:28-48	Non-ionizing radiation producing sources: extension of comment period regarding registration fees	26 N.J.R. 793(b)		
7:50-2, 3, 4, 5, 6, 7	Pinelands Comprehensive Management Plan	26 N.J.R. 165(a)		
7:61-3.15, 3.16	Board of Commissioners of Pilotage: Drug Free Workplace Program	26 N.J.R. 2238(a)		
	Most recent update to Title 7: TRANSMITTAL 1994-6 (supplement June 20, 1994)			
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8:1-1	Disability discrimination grievance procedure	26 N.J.R. 2005(a)		
8:8	Collection, processing, storage and distribution of blood	26 N.J.R. 2025(a)	R.1994 d.350	26 N.J.R. 3171(a)
8:8-8.3, 8.5, 8.8	Collection of human blood	26 N.J.R. 3141(a)		
8:31B-2.1, 2.3, 2.4, 2.5	Hospital reporting of uniform bill-patient summaries (inpatient)	26 N.J.R. 10(a)		
8:31B-3.3, 3.70	Health care financing: monitoring and reporting	26 N.J.R. 12(a)		
8:31B-4.37	Charity care audit functions	26 N.J.R. 13(a)		
8:36-1.8, 9.3	Assisted living residences and comprehensive personal care homes: personal care assistants; administration of medications	26 N.J.R. 2187(a)		
8:38-1–3	Health Maintenance Organizations	26 N.J.R. 1624(a)	R.1994 d.365	26 N.J.R. 2896(a)
8:39	Long-term care facilities: standards for licensure	26 N.J.R. 1772(c)		
8:42A	Licensure of alcoholism treatment facilities	26 N.J.R. 1625(a)	R.1944 d.366	26 N.J.R. 2896(b)
8:43D	Health Care Administration Board bylaws	26 N.J.R. 1627(a)		
8:43H	Licensure of rehabilitation hospitals	26 N.J.R. 1628(a)	R.1994 d.367	26 N.J.R. 2896(c)
8:44-2.5	Clinical laboratory Proficiency Testing Program	26 N.J.R. 1070(a)		
8:44-2.11	Clinical laboratories: reopening of comment period on reporting of blood lead levels	26 N.J.R. 1190(a)		
8:59	Worker and Community Right to Know Act rules	26 N.J.R. 2888(a)		
8:59-App. A, B	Worker and Community Right to Know Hazardous Substance List	26 N.J.R. 540(a)		
8:65-10.1, 10.2	Controlled dangerous substances	26 N.J.R. 1630(a)	R.1993 d.325	26 N.J.R. 2792(b)
8:71	Interchangeable drug products (see 25 N.J.R. 4495(b), 6062(a), 364(b))	25 N.J.R. 2802(b)	R.1994 d.245	26 N.J.R. 2094(c)
8:71	Interchangeable drug products (see 25 N.J.R. 6060(c))	25 N.J.R. 3906(a)	R.1994 d.39	26 N.J.R. 364(a)
8:71	Interchangeable drug products (see 26 N.J.R. 362(b), 1347(b))	25 N.J.R. 4844(a)	R.1994 d.246	26 N.J.R. 2095(a)
8:71	List of Interchangeable Drug Products (see 26 N.J.R. 1348(a))	26 N.J.R. 13(b)	R.1994 d.247	26 N.J.R. 2096(a)
8:71	List of Interchangeable Drug Products	26 N.J.R. 14(a)	R.1994 d.244	26 N.J.R. 2039(a)
8:71	List of Interchangeable Drug Products	26 N.J.R. 69(a)	R.1994 d.243	26 N.J.R. 2028(a)
8:71	Interchangeable drug products (see 26 N.J.R. 2025(b))	26 N.J.R. 1190(b)	R.1994 d.370	26 N.J.R. 2901(a)
8:71	Interchangeable drug products	26 N.J.R. 1821(a)	R.1994 d.368	26 N.J.R. 2897(a)
8:71	Interchangeable drug products	26 N.J.R. 1822(a)	R.1994 d.369	26 N.J.R. 2898(a)
8:71	Interchangeable drug products	26 N.J.R. 2723(a)		
8:91	Health Access New Jersey	26 N.J.R. 2007(a)		
	Most recent update to Title 8: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
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9:4-1.7	Curriculum coordinating committee	26 N.J.R. 1751(a)		
9:11-2, 3, 4	Graduate EOF financial eligibility; Martin Luther King Physician-Dentist Scholarship; C. Clyde Ferguson Law Scholarship	26 N.J.R. 1932(a)		
	Most recent update to Title 9: TRANSMITTAL 1994-4 (supplement June 20, 1994)			
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10:17	Child placement rights	26 N.J.R. 1563(a)		
10:18	Manual of Standards for Juvenile Detention Commitment Programs	25 N.J.R. 5749(a)	R.1994 d.392	26 N.J.R. 2902(a)
10:37-6.1–6.4, 6.8, 6.9, 6.25, 6.26, 6.30–6.33, 6.37, 6.38, 6.58, 7.1–7.9	Repeal (see 10:37D)	26 N.J.R. 1277(a)		
10:37C	Community mental health clinical case management	25 N.J.R. 4845(a)	R.1994 d.336	26 N.J.R. 3082(b)
10:37D	Division of Mental Health and Hospitals: management and governing body standards for provider agencies	26 N.J.R. 1277(a)		
10:43	Division of Developmental Disabilities: determination of need for guardian	26 N.J.R. 2838(a)		
10:48-1	Division of Developmental Disabilities: appeal procedure	26 N.J.R. 1280(a)		
10:48-4	Eligibility for services	26 N.J.R. 1752(a)		

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10:48-4	Division of Developmental Disabilities: public hearing and reopening of comment period regarding management of waiting lists for services	26 N.J.R. 2756(a)		
10:49-14.1	Medicaid benefits: recovery from estates of payments correctly made	26 N.J.R. 2757(a)		
10:49-17.5	Home care services: Traumatic Brain Injury Program	26 N.J.R. 1566(a)	R.1994 d.426	26 N.J.R. 3466(b)
10:50-1.2, 1.3, 1.4, 1.6, 1.7, 2.2	Transportation services for Medicaid recipients	26 N.J.R. 1425(a)	R.1994 d.402	26 N.J.R. 3211(b)
10:52-8.2	Manual of Hospital Services: disproportionate share adjustment for Other Uncompensated Care component	26 N.J.R. 2239(a)		
10:52-8.2	Manual for Hospital Services: payments for beds for mentally ill and developmentally disabled clients	26 N.J.R. 2241(a)	R.1994 d.432	26 N.J.R. 3473(a)
10:52-8.2	Charity care component of Health Care Subsidy Fund	Emergency (expires 9-30-94)	R.1994 d.440	26 N.J.R. 3485(a)
10:53A-3.2, 3.4	Hospice Services Manual: determination of Medicaid eligibility	26 N.J.R. 1283(a)		
10:59-1.9	Medical Supplier Manual: reimbursement for certain services	26 N.J.R. 2839(a)		
10:60-1.3	Home Care Services: accreditation of private duty nursing agencies	26 N.J.R. 2840(a)		
10:60-5	Home care services: Traumatic Brain Injury Program	26 N.J.R. 1566(a)	R.1994 d.426	26 N.J.R. 3466(b)
10:65-1.1, 1.2, 1.4, 1.5, 1.7, 1.8, 2.1, 2.2, App. H	Pediatric medical day care services	26 N.J.R. 1427(a)	R.1994 d.427	26 N.J.R. 3474(a)
10:69A-5.3, 5.6, 6.2, 6.12	Pharmaceutical Assistance to the Aged and Disabled: eligibility and income criteria	26 N.J.R. 3142(a)		
10:71-4.8, 5.4, 5.5, 5.6, 5.9	Medicaid Only: eligibility computation amounts	26 N.J.R. 1754(a)	R.1994 d.428	26 N.J.R. 3478(a)
10:81	Public Assistance Manual	26 N.J.R. 1573(a)	R.1994 d.429	26 N.J.R. 3479(a)
10:81-2.2, 2.3, 5.1, 7.40-7.47, 15	Fraudulent receipt of AFDC assistance; disqualification penalties	25 N.J.R. 3408(a)		
10:81-11.2, 11.4, 11.18A	Public Assistance Manual: assignment of right to support; wage withholding	26 N.J.R. 896(a)		
10:81-11.9	Public Assistance Manual: $50 disregarded child support payment	26 N.J.R. 1937(a)		
10:82	Aid to Families with Dependent Children (AFDC)	26 N.J.R. 1584(a)	R.1994 d.430	26 N.J.R. 3483(a)
10:85	General Assistance Manual	26 N.J.R. 2757(b)		
10:85-4.6	General Assistance Program: extension of temporary rental assistance benefits	26 N.J.R. 1756(a)		
10:95	Commission for the Blind and Visually Impaired: Vocational Rehabilitation Services Program	26 N.J.R. 2242(a)		
10:126-1.2, 1.4, 2.2–2.4, 2.6, 3.2, 4.1, 4.2, 4.6, 4.8, 5.1–5.4, 5.6–5.10, 6.1–6.6, 6.8, 6.9, 6.13, 6.18, 6.20	Manual of Requirements for Family Day Care Registration	26 N.J.R. 3144(a)		
10:133-1.3	DYFS: initial response and service delivery definitions	26 N.J.R. 1285(a)		
10:133C-2	Eligibility for DYFS services	26 N.J.R. 897(a)		
10:133H-3	Review of children in out-of-home placement	25 N.J.R. 5752(a)		
10A:33	Manual of Standards for Juvenile Detention Commitment Programs (recodified to 10:18	25 N.J.R. 5749(a)	R.1994 d.392	26 N.J.R. 2902(a)

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10A:6-2.2, 2.7	Inmate legal services: use of typewriters	26 N.J.R. 2188(a)	R.1994 d.410	26 N.J.R. 3178(a)
10A:20-4.20, 4.21, 4.22, 4.45	Community release programs	26 N.J.R. 1757(a)	R.1994 d.340	26 N.J.R. 2792(c)
10A:20-4.20, 4.21, 4.22, 4.45	Community release programs	26 N.J.R. 1938(a)	R.1994 d.340	26 N.J.R. 2792(c)
10A:31-1.3, 8.4, 8.6	Adult county correctional facilities: strip and body cavity searches	26 N.J.R. 2841(a)		
10A:33	Manual of Standards for Juvenile Detention Commitment Programs	25 N.J.R. 5749(a)	R.1994 d.392	26 N.J.R. 2902(a)
10A:71-3.15, 3.16	State Parole Board: parole hearings	26 N.J.R. 2189(a)		
10A:71-3.21	State Parole Board: future parole eligibility terms	25 N.J.R. 4703(a)		
10A:71-7.16, 7.16A	Parole Board panel action: establishment of parole release date upon revocation of parole for technical violations	26 N.J.R. 2516(a)		

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11:1-7	Medical malpractice reporting requirements	26 N.J.R. 1433(a)		
11:3-16.7	Automobile insurers rate filing requirements	26 N.J.R. 900(a)		
11:3-20.6	Private passenger automobile insurers: reporting financial disclosure and excess profits	26 N.J.R. 1938(b)	R.1994 d.425	26 N.J.R. 3441(b)
11:3-28.2, 28.14–28.17	Unsatisfied Claim and Judgment Fund: uninsured motorists case assignment procedures	26 N.J.R. 2190(a)		
11:3-29.2, 37.10	Automobile insurance PIP coverage: application of medical fee schedules to acute care hospitals and other facilities	25 N.J.R. 4706(a)		
11:3-29.6	Personal auto injury fee schedule: physician's services	25 N.J.R. 4554(a)		
11:3-32	Automobile and motor vehicle insurers: certification of compliance with mandatory liability coverages	26 N.J.R. 1939(a)		
11:5-1.2, 1.4, 1.5, 1.19, 1.29	Real Estate Commission: licensing requirements	26 N.J.R. 3111(a)		
11:5-1.7	Real Estate Commission: preproposal concerning mass marketing and brokerage licensure requirement	26 N.J.R. 3110(a)		
11:5-1.27	Real Estate Commission: administrative correction regarding application for licensure examination	———	———	26 N.J.R. 3442(a)
11:5-1.43	Real Estate Commission: consumer information statement	26 N.J.R. 3113(a)		
11:15	Group self-insurance	26 N.J.R. 2518(a)		
11:15-2	Joint insurance funds for local governmental units	26 N.J.R. 2725(a)		
11:17-3, 5.1–5.4, 5.6, 5.7	Professional qualifications of insurance producers	26 N.J.R. 1289(a)		
11:18	Medical Malpractice Reinsurance Recovery Fund surcharge	26 N.J.R. 2195(a)		
11:19-4	Financial Examinations Monitoring System: data submission requirements for domestic life/health insurers	26 N.J.R. 1195(a)		
11:20-9.6	Individual Health Coverage Program: Good Faith Marketing Report	26 N.J.R. 2737(a)	R.1994 d.352	26 N.J.R. 2904(a)
11:21-3.2, 4.1, 6.3, 7.15, Exh. A–F	Small Employer Health Benefits Program: enrollment, permissible rate classification factors, optional benefit riders	26 N.J.R. 2843(a)	R.1994 d.418	26 N.J.R. 3442(b)
11:21-7.4	Small Employer Health Benefits Program: carriers acting as administrators for small employers	26 N.J.R. 3117(a)		
11:21-9.1–9.4, 11, 14.2, 14.4, 14.5, 16.2, 16.3, 16.4, 16.7, Exh. BB, U	Small Employer Health Benefits Program: plan filings; informational rate filings; declaration and approval of carrier status; withdrawals of carriers from plan market	26 N.J.R. 3118(a)		
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12:18-2.6, 2.38, 2.41–2.48	Temporary Disability Benefits appeal hearings	26 N.J.R. 2195(b)	R.1994 d.407	26 N.J.R. 3178(b)
12:18 App.	Department of Labor hearings	26 N.J.R. 2174(a)		
12:20	Board of Review and Appeal Tribunal	26 N.J.R. 1941(a)		
12:20	Department of Labor hearings	26 N.J.R. 2174(a)		
12:20	Board of Review regarding unemployment benefits appeals	26 N.J.R. 2196(a)	R.1994 d.408	26 N.J.R. 3179(a)
12:23-1, 2	Workforce Development Partnership Program: application and review process for customized training services	26 N.J.R. 2770(a)		
12:23-5.9	Workforce Development Partnership Program: overpayments of additional unemployment benefits	26 N.J.R. 2198(a)	R.1994 d.409	26 N.J.R. 3180(a)
12:23-7	Workforce Development Partnership Program: occupational safety and health training services	26 N.J.R. 2774(a)		
12:41-1.2, 1.14	Job Training Partnership Act: non-criminal complaints and appeals	26 N.J.R. 2864(a)		
12:56-6.1, 7.5, 7.6	Wage and Hour compliance: limousine operators	26 N.J.R. 94(a)		
12:100	Safety and Health Standards for Public Employees	26 N.J.R. 2776(a)		
12:195-1.9	Carnival-amusement rides: inspection fees	26 N.J.R. 2520(a)		
12:235-9.4	Workers' Compensation: appeals regarding discrimination complaints	26 N.J.R. 1591(b)	R.1994 d.431	26 N.J.R. 3459(a)
12:235-9.4	Workers' Compensation: extension of comment period regarding discrimination complaint determinations	26 N.J.R. 2777(a)		
12:235-14.7	Uninsured Employer's Fund: attorney fees	26 N.J.R. 2199(a)		
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12A:10-1	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		

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12A:10-2	Minority and female contractor and subcontractor participation in State construction contracts	25 N.J.R. 4461(b)		
12A:31-1.4	Development Authority for Small Businesses, Minorities' and Women's Enterprises: allocation of direct loan assistance	25 N.J.R. 5759(a)		
12A:31-1.4	Development Authority for Small Businesses, Minorities' and Women's Enterprises: reopening of comment period regarding allocation of direct loan assistance	26 N.J.R. 1434(a)		
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13:4	Housing discrimination	26 N.J.R. 1942(a)		
13:9-1.1	Housing discrimination	26 N.J.R. 1942(a)		
13:13	Housing discrimination	26 N.J.R. 1942(a)		
13:18-1.5–1.9, 1.12, 1.15	Division of Motor Vehicles: overweight oceanborne containers	26 N.J.R. 2521(a)		
13:19	Division of Motor Vehicles: Driver Control Service	26 N.J.R. 2738(a)		
13:19-1.1	Division of Motor Vehicles: applicability of administrative hearings	26 N.J.R. 2522(a)		
13:19-10, 12, 13	Driver Control Service rules: waiver of Executive Order No. 66(1978) expiration date	———	———	26 N.J.R. 2905(a)
13:21-6.1, 6.2, 6.3, 7.1, 7.2, 7.3, 7.4, 8.1, 8.2, 8.4, 16	Division of Motor Vehicles: permits, licenses, nondriver IDs	26 N.J.R. 2522(a)		
13:21-24	Division of Motor Vehicles: defensive driving courses	26 N.J.R. 1592(a)	R.1994 d.347	26 N.J.R. 2793(a)
13:24	Division of Motor Vehicles: equipment for emergency and other specified vehicles	26 N.J.R. 2865(a)		
13:25-1.1, 2.1, 2.2, 3.1, 3.3	Division of Motor Vehicles: motorized bicycle permits and licenses	26 N.J.R. 2522(a)		
13:27-6.2	Board of Architects: depiction of existing conditions on a site plan	26 N.J.R. 1221(a)	R.1994 d.321	26 N.J.R. 2794(a)
13:27-6.2	Board of Architects: administrative correction regarding depiction of existing conditions on a site plan	———	———	26 N.J.R. 3180(b)
13:28-5.1	Board of Cosmetology and Hairstyling: fee schedule	26 N.J.R. 1947(a)	R.1994 d.415	26 N.J.R. 3181(a)
13:30-8.18	Board of Dentistry: licensee continuing education	26 N.J.R. 1948(a)		
13:31-1.3	Board of Examiners of Electrical Contractors: licensing examination	26 N.J.R. 1218(a)	R.1994 d.331	26 N.J.R. 2795(a)
13:31-1.9	Board of Examiners of Electrical Contractors: identification of licensee vehicles	26 N.J.R. 1218(b)		
13:31-1.10	Board of Examiners of Electrical Contractors: duty of licensee to return pressure seal	26 N.J.R. 1594(a)	R.1994 d.332	26 N.J.R. 2795(b)
13:31-1.11, 1.16	Board of Examiners of Electrical Contractors: fee schedule; requirement of ID card defined	26 N.J.R. 2742(a)		
13:33-4.1	Board of Ophthalmic Dispensers and Ophthalmic Technicians: contact lens dispensing	26 N.J.R. 1595(a)		
13:35	Board of Medical Examiners rules	26 N.J.R. 2526(a)		
13:35-2B, 6.14	Board of Medical Examiners: physician assistants	25 N.J.R. 5099(b)		
13:35-3.12	Board of Medical Examiners: licensure of physicians with post-secondary educational deficiencies	26 N.J.R. 2742(b)		
13:35-5.1	Board of Medical Examiners: release of contact lens specification to patient	26 N.J.R. 1219(a)		
13:35-6.10	Board of Medical Examiners: licensee testimonial advertisements	26 N.J.R. 1219(b)	R.1994 d.329	26 N.J.R. 2795(c)
13:35-6.17	Board of Medical Examiners: professional fees and investments	25 N.J.R. 5441(a)		
13:35-8.7, 8.8	Board of Medical Examiners: fitting and dispensing of deep ear canal hearing aid devices	26 N.J.R. 1301(b)		
13:36	Board of Mortuary Science rules	26 N.J.R. 2536(a)		
13:37-14	Homemaker-home health aide competency evaluation: public hearing	25 N.J.R. 3704(b)		
13:38-6.1	Board of Optometrists: release of contact lens specification to patient	26 N.J.R. 1220(a)		
13:39	Board of Pharmacy rules	26 N.J.R. 1596(a)	R.1994 d.351	26 N.J.R. 2905(b)
13:39-1.2, 6.7, 9.1, 9.7, 10.4, 11.1	Board of Pharmacy: pharmacy technicians	26 N.J.R. 2743(a)		
13:39-10.2, 11	Board of Pharmacy: sterile admixture services in retail pharmacies	26 N.J.R. 1303(a)		
13:39A-2.3	Board of Physical Therapy: public forum on direct supervision of physical therapist assistants	26 N.J.R. 1604(a)		
13:40-7.2	Board of Professional Engineers and Land Surveyors: depiction of existing conditions on a site plan	26 N.J.R. 1221(a)	R.1994 d.322	26 N.J.R. 2796(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
13:40-7.2	Board of Professional Engineers and Land Surveyors: administrative correction regarding depiction of existing conditions on a site plan	———	———	26 N.J.R. 3180(b)
13:40A-2A.3	Board of Real Estate Appraisers: certification as residential appraiser	26 N.J.R. 902(a)	R.1994 d.420	26 N.J.R. 3460(a)
13:41-4.2	Board of Professional Planners: depiction of existing conditions on a site plan	26 N.J.R. 1221(a)	R.1994 d.394	26 N.J.R. 3181(b)
13:42-1.1, 1.2, 4.5, 9.9	Board of Psychological Examiners rules	25 N.J.R. 4937(a)		
13:44	Board of Veterinary Medical Examiners: practice standards	26 N.J.R. 1951(a)		
13:44D	Board of Public Movers and Warehousemen: licensee standards	26 N.J.R. 1758(a)	R.1994 d.395	26 N.J.R. 3182(a)
13:44D-2.2, 2.6	Board of Public Movers and Warehousemen: licensee mailing address and permanent place of business	26 N.J.R. 2745(a)		
13:44D-4.1, 4.2	Advisory Board of Public Movers and Warehousemen: bill of lading and insurance legal liability	25 N.J.R. 5449(a)		
13:44E-1.1	Board of Chiropractic Examiners: scope of chiropractic practice	25 N.J.R. 3931(b)		
13:44E-2.1	Board of Chiropractic Examiners: licensee advertising	25 N.J.R. 3932(a)		
13:44E-2.2	Board of Chiropractic Examiners: patient records and cessation of practice	26 N.J.R. 2866(a)		
13:44E-2.6	Board of Chiropractic Examiners: practice identification educational requirements	25 N.J.R. 3934(a)		
13:44E-2.8	Board of Chiropractic Examiners: duties of unlicensed assistants	25 N.J.R. 3935(a)		
13:44E-2.13	Board of Chiropractic Examiners: overutilization; excessive fees	26 N.J.R. 1231(b)		
13:45A-16.1	Home improvement practices: security protection devices	26 N.J.R. 1605(a)	R.1994 d.396	26 N.J.R. 3183(a)
13:45A-27	Division of Consumer Affairs: licensee duty to cooperate with licensing board or agency	26 N.J.R. 3128(a)		
13:46-2	Athletic Control Board: participant health and safety in boxing and combative sports events	25 N.J.R. 4717(a)		
13:47C	Weights and measures: general commodities	26 N.J.R. 1761(a)	R.1994 d.330	26 N.J.R. 2796(b)
13:48	Charitable fund raising	26 N.J.R. 2746(a)		
13:70-8.18	Thoroughbred racing: items included in jockey's weight	26 N.J.R. 3130(a)		
13:70-8.18	Thoroughbred racing: overweight of jockey after race	26 N.J.R. 3130(b)		
13:70-14A.1	Thoroughbred racing: administration of phenylbutazone on day of race	26 N.J.R. 1955(a)		
13:70-14A.8	Thoroughbred racing: possession of drugs or drug instruments	26 N.J.R. 1315(a)		
13:70-14A.9	Thoroughbred racing: administration of phenylbutazone on day of race	26 N.J.R. 1956(a)		
13:70-19.44	Thoroughbred racing: conflicts of interest involving veterinary practitioner and spouse	25 N.J.R. 5107(a)		
13:71-9.5	Harness racing: conflicts of interest involving veterinary practitioner and spouse	25 N.J.R. 5108(a)		
13:71-23.1	Thoroughbred racing: administration of phenylbutazone on day of race	26 N.J.R. 1956(b)		
13:71-23.8	Thoroughbred racing: administration of phenylbutazone on day of race	26 N.J.R. 1957(a)		
13:71-23.9	Harness racing: possession of drugs or drug instruments	26 N.J.R. 1316(a)		
13:72-2.11, 4.10	Racing Commission: casino simulcasting and cancellation of incorrect pari-mutuel tickets	26 N.J.R. 2546(a)		
13:75	Violent Crimes Compensation Board: practice and procedure	26 N.J.R. 1491(a)	R.1994 d.364	26 N.J.R. 2805(b)

Most recent update to Title 13: TRANSMITTAL 1994-6 (supplement June 20, 1994)

PUBLIC UTILITIES (BOARD OF REGULATORY COMMISSIONERS)—TITLE 14

14:0	IntraLATA competition for telecommunications services: preproposal	25 N.J.R. 3682(b)		
14:0	Intrastate dial-around compensation: preproposal	25 N.J.R. 4586(a)		
14:18-3.24	Cable television: late fees and charges	26 N.J.R. 105(a)		

Most recent update to Title 14: TRANSMITTAL 1994-3 (supplement May 16, 1994)

ENERGY—TITLE 14A

Most recent update to Title 14A: TRANSMITTAL 1994-1 (supplement February 22, 1994)

STATE—TITLE 15

15:10-8	Certification of electronic voting systems	25 N.J.R. 4587(a)		
15:10-8	Certification of electronic voting systems: public hearing and extension of comment period	25 N.J.R. 4864(a)		

Most recent update to Title 15: TRANSMITTAL 1993-3 (supplement December 20, 1993)

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PUBLIC ADVOCATE—TITLE 15A				
	Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)			
TRANSPORTATION—TITLE 16				
16:1A	Administration, organization and management of the Department of Transportation	Exempt	R.1994 d.348	26 N.J.R. 2797(a)
16:6	Relocation assistance and right-of-way acquisition	26 N.J.R. 1958(a)	R.1994 d.400	26 N.J.R. 3183(b)
16:26	Bureau of Electrical Engineering	26 N.J.R. 1764(a)	R.1994 d.401	26 N.J.R. 3183(c)
16:28-1.5	Speed limit zones along Route 37 in Ocean County	26 N.J.R. 1958(b)	R.1994 d.381	26 N.J.R. 3183(d)
16:28-1.6	School zone along U.S. 40 in Woodstown Borough, Salem County	26 N.J.R. 3131(a)		
16:28-1.10	Speed limit zones along U.S. 46, including U.S. 1, 9 and 46, in Washington Township	26 N.J.R. 1959(a)	R.1994 d.383	26 N.J.R. 3184(b)
16:28-1.10	Speed limit zones along U.S. 46, including U.S. 1, 9 and 46, in Dover	26 N.J.R. 1960(a)	R.1994 d.382	26 N.J.R. 3184(a)
16:28-1.18	Speed limit zones along Route 34 in Aberdeen and Matawan	26 N.J.R. 1765(a)	R.1994 d.353	26 N.J.R. 2912(a)
16:28-1.25	Speed limit zones along Route 23 in Franklin Borough, Sussex County	26 N.J.R. 2749(a)		
16:28-1.41	School zone along U.S. 9 in Lower Township, Cape May County	26 N.J.R. 1765(b)	R.1994 d.354	26 N.J.R. 2913(a)
16:28-1.41	Speed limit zones along U.S. 9 in Ocean County	26 N.J.R. 1960(b)	R.1994 d.385	26 N.J.R. 3184(c)
16:28-1.41	Speed limit zones along U.S. 9 in Galloway Township, Atlantic County	26 N.J.R. 3132(a)		
16:28-1.69	Speed limit zones along U.S. 130, including parts of I-295, U.S. 30 and U.S. 206 in Salem County	26 N.J.R. 1766(a)	R.1994 d.362	26 N.J.R. 2913(b)
16:28-1.72	Speed limit zones along U.S. 206, including U.S. 206 and 130, in Morris County	26 N.J.R. 1961(a)	R.1994 d.386	26 N.J.R. 3185(a)
16:28-1.79	Speed limit zones along Route 94 in Sussex County	26 N.J.R. 3133(a)		
16:28-1.96	Speed limit zones along Route 45 in Gloucester County	26 N.J.R. 1962(a)	R.1994 d.387	26 N.J.R. 3185(b)
16:28-1.106	Speed limit zones along Route 31 in Clinton Township	26 N.J.R. 1963(a)	R.1994 d.388	26 N.J.R. 3186(a)
16:28-1.132	Speed limit zones along Route 47 in Middle Township	26 N.J.R. 1767(a)	R.1994 d.361	26 N.J.R. 2913(c)
16:28-1.132	Speed limit zones along Route 47 in Dennis Township, Cape May	26 N.J.R. 2867(a)		
16:28-1.182	Speed limits along Wyckoff Mills Road in Howell Township	26 N.J.R. 1767(b)	R.1994 d.358	26 N.J.R. 2914(a)
16:28-1.183	Speed limits along Frontage Road in Union Township, Hunterdon County	26 N.J.R. 1768(a)	R.1994 d.359	26 N.J.R. 2914(b)
16:28A-1.22	No stopping or standing zones along Route 31 in East Amwell Township	26 N.J.R. 1768(b)	R.1994 d.363	26 N.J.R. 2914(c)
16:28A-1.23	No stopping or standing zones along Route 33 in Manalapan Township	26 N.J.R. 1963(b)	R.1994 d.384	26 N.J.R. 3186(b)
16:28A-1.25	No stopping or standing zones along Route 35 in Berkeley Township	26 N.J.R. 2749(b)		
16:28A-1.28	Restricted parking and stopping along Route 40 in Hamilton Township, Atlantic County	26 N.J.R. 1769(a)	R.1994 d.360	26 N.J.R. 2914(d)
16:28A-1.33	Parking restrictions along Route 47 for entire length	26 N.J.R. 2867(b)		
16:28A-1.41	Time limit parking on Route 77 in Bridgeton: correction to proposal	25 N.J.R. 3944(a)		
16:28A-1.44	No stopping or standing zones along Route 88 in Lakewood Township, Ocean County	26 N.J.R. 3135(a)		
16:28A-1.57	No stopping or standing along U.S. 206 in Mount Olive	26 N.J.R. 2200(a)	R.1994 d.421	26 N.J.R. 3460(b)
16:28A-1.98	No stopping or standing zones along Route 56 in Deerfield Township, Cumberland County	26 N.J.R. 3136(a)		
16:28A-1.113	No stopping or standing zones along Route 33 (Business) in Manalapan Township	26 N.J.R. 1964(a)	R.1994 d.391	26 N.J.R. 3186(c)
16:30-3.11	Left turn lane along Route 38 in Lumberton and Southampton townships: correction to proposal and extension of comment period	26 N.J.R. 1317(a)		
16:30-7.3	Limited access prohibition along Route 55 Freeway in Cumberland, Salem, and Gloucester counties	26 N.J.R. 1769(b)	R.1994 d.355	26 N.J.R. 2915(a)
16:30-7.6	Limited access prohibitions along Route 18 Freeway in Monmouth and Middlesex counties	26 N.J.R. 1965(a)	R.1994 d.389	26 N.J.R. 3187(a)
16:30-7.7	Limited access prohibitions along Route 42 Freeway in Gloucester and Camden counties	26 N.J.R. 1964(b)	R.1994 d.390	26 N.J.R. 3187(b)
16:31-1.1	Left turn prohibition on U.S. 206 at Valley Road in Hillsborough Township	26 N.J.R. 2547(a)		
16:31-1.3	Turn prohibitions on Route 46 in Mount Olive Township, Morris County	26 N.J.R. 1771(a)	R.1994 d.356	26 N.J.R. 2915(b)
16:31-1.8	Turn prohibitions on Route 47 in the City of Vineland, Cumberland County	26 N.J.R. 1770(a)	R.1994 d.357	26 N.J.R. 2915(c)
16:31-1.17	Left turn prohibition along Route 73 in Berlin Township, Camden County	26 N.J.R. 3137(a)		
16:31-1.22	Turn prohibitions along U.S. 130 in Burlington and Mercer counties	26 N.J.R. 2870(a)		

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16:31-1.29	Left turn prohibitions along U.S. 9 in Lakewood Township, Ocean County	26 N.J.R. 3137(b)		
16:31-1.35	U turn prohibitions along Route 42 in Gloucester County	26 N.J.R. 2750(a)		
16:31-1.36	Turn prohibitions along U.S. 40/322 in Egg Harbor Township	26 N.J.R. 2871(a)		
16:45	Construction control	26 N.J.R. 2547(b)		
16:47-1.1, 3.5, 3.8, 3.9, 3.12, 3.16, 4.3, 4.6, 4.7, 4.9, 4.10, 4.12, 4.14, 4.24, 4.25, 4.26, 4.27, 4.29, 4.33, 4.34, 4.35, 4.36, 4.37, 5.2, App. B, C, E, L	State Highway Access Management Code	26 N.J.R. 2549(a)		
16:50-8.9, 11	Employer Trip Reduction Program: employee transportation coordinator training; disclosure of information	25 N.J.R. 5452(a)		
16:50-15	Employer Trip Reduction Program tax credit	26 N.J.R. 756(a)		
16:51	Regulation of autobuses and transportation public utilities: pre-proposal	26 N.J.R. 1317(b)		
16:53	Autobuses	26 N.J.R. 1606(a)	R.1994 d.346	26 N.J.R. 2798(a)
16:53D	Regulation of autobuses and transportation public utilities: pre-proposal	26 N.J.R. 1317(b)		
16:56	Airport safety improvement aid	26 N.J.R. 1607(a)	R.1994 d.372	26 N.J.R. 2916(a)
16:82	Examination and duplication of NJ TRANSIT records	26 N.J.R. 2871(b)		

Most recent update to Title 16: TRANSMITTAL 1994-6 (supplement June 20, 1994)

TREASURY-GENERAL—TITLE 17

17:1-1.16	State-administered retirement systems: lost pension checks	26 N.J.R. 2200(b)	R.1994 d.416	26 N.J.R. 3460(c)
17:1-4.32	Workers' Compensation: reduction of retirement allowance	26 N.J.R. 2201(a)	R.1994 d.424	26 N.J.R. 3461(a)
17:9-4.1, 4.5	State Health Benefits Program: appointive officer eligibility	26 N.J.R. 109(a)		
17:9-4.2, 8.3, 9.1	State Health Benefits Program: continued coverage under voluntary furlough program	26 N.J.R. 2202(a)		
17:13	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		
17:14	Minority and female contractor and subcontractor participation in State construction contracts	25 N.J.R. 4461(b)		
17:16-20.2	State Investment Council: permissible international investments by State-administered pension funds	26 N.J.R. 2751(a)		
17:16-62.11	State Investment Council: Common Pension Fund A realized appreciation	26 N.J.R. 1771(b)	R.1994 d.326	26 N.J.R. 2798(b)
17:16-63.11	State Investment Council: Common Pension Fund B realized appreciation	26 N.J.R. 1772(a)	R.1994 d.327	26 N.J.R. 2798(c)
17:16-67.11	State Investment Council: Common Pension Fund D realized appreciation	26 N.J.R. 1772(b)	R.1994 d.328	26 N.J.R. 2798(d)

Most recent update to Title 17: TRANSMITTAL 1994-4 (supplement June 20, 1994)

TREASURY-TAXATION—TITLE 18

18:1	Organization of Division of Taxation	26 N.J.R. 2752(a)		
18:7-15.1–15.5	Corporation Business Tax: urban enterprise zone credits	26 N.J.R. 2203(a)	R.1994 d.419	26 N.J.R. 3462(a)

Most recent update to Title 18: TRANSMITTAL 1994-4 (supplement June 20, 1994)

TITLE 19—OTHER AGENCIES

19:2	South Jersey Transportation Authority: rules of operation; Atlantic City Expressway	26 N.J.R. 1966(a)		
19:3, 3A, 4, 5	Hackensack Meadowlands Development District rules	26 N.J.R. 1970(a)		
19:9-1	Turnpike Authority: traffic control	26 N.J.R. 337(a)	R.1994 d.414	26 N.J.R. 3463(a)
19:10	Public Employment Relations Commission: definitions, service, construction	26 N.J.R. 2205(a)		
19:25-1.7, 6.5–6.9	ELEC: permissible uses of candidate funds	26 N.J.R. 2753(a)		
19:25-9, 10	Reporting by continuing political committees, political party committees, and legislative leadership committees	26 N.J.R. 3138(a)		
19:31-8.2, 8.3	Hazardous Discharge Site Remediation Fund	26 N.J.R. 1612(b)	R.1994 d.375	26 N.J.R. 2918(a)
19:31-9	New Jersey Boat Industry Loan Guarantee Fund	26 N.J.R. 1613(a)	R.1994 d.376	26 N.J.R. 2919(a)

Most recent update to Title 19: TRANSMITTAL 1994-6 (supplement June 20, 1994)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY				
19:40	General provisions	26 N.J.R. 2564(a)		
19:40-1.2	Gaming chips and plaques	26 N.J.R. 1441(b)		
19:40-1.2	Slot tokens, prize tokens, slot machine hoppers	26 N.J.R. 2872(a)		
19:40-1.2	Removal of coin, slot tokens and slugs from slot machines	26 N.J.R. 1620(a)	R.1994 d.423	26 N.J.R. 3465(a)
19:40-4.1, 4.2, 4.8	Confidential information	26 N.J.R. 1434(a)		
19:41-1.3	Keno	26 N.J.R. 2218(a)		
19:41-1.5A, 1.8, 1.9	Qualification standards for casino employees and gaming school instructors	26 N.J.R. 2207(a)		
19:41-1.6	Casino employee license position endorsements	26 N.J.R. 910(a)		
19:41-6.1–6.5	Statements of compliance	26 N.J.R. 1319(a)		
19:41-7.2A	Applicant identification for license or registration	26 N.J.R. 2565(a)		
19:41-8.8	Reapplication for license, registration, qualification or approval after denial or revocation	26 N.J.R. 1993(a)		
19:42-3.6	Casino licensee application requirements; renewal of casino license	26 N.J.R. 1615(a)	R.1994 d.341	26 N.J.R. 2798(e)
19:43-5, 11	Casino licensee application requirements; renewal of casino license	26 N.J.R. 1615(a)	R.1994 d.341	26 N.J.R. 2798(e)
19:43-6.1–6.9	Casino hotel facility requirements	26 N.J.R. 1206(a)	R.1994 d.342	26 N.J.R. 2801(a)
19:44-2.6, 2.7, 5.1	Gaming schools	26 N.J.R. 1617(a)	R.1994 d.343	26 N.J.R. 2803(a)
19:44-5.2, 8.3, 8.6	Qualification standards for casino employees and gaming school instructors	26 N.J.R. 2207(a)		
19:45-1	Slot tokens, prize tokens, slot machine hoppers	26 N.J.R. 2872(a)		
19:45-1.1	Gaming chips and plaques	26 N.J.R. 1441(b)		
19:45-1.1, 1.1A, 1.2, 1.8, 1.10, 1.11, 1.12, 1.15, 1.19, 1.25, 1.33, 1.46–1.51	Keno	26 N.J.R. 2218(a)		
19:45-1.1, 1.9B, 1.24, 1.26, 1.27, 1.29	Use of cash complimentary gifts	26 N.J.R. 2212(a)		
19:45-1.1, 1.15, 1.20, 1.25, 1.39B, 1.52	Caribbean stud poker: temporary adoption	_____	_____	26 N.J.R. 3464(a)
19:45-1.24A	Release of wire transfer funds: patron identification procedure	26 N.J.R. 3140(a)		
19:45-1.1, 1.25	Exchange of annuity jackpot checks	26 N.J.R. 2211(a)		
19:45-1.1, 1.37A, 1.39	Electronic transfer credit systems at slot machines; progressive slot machines	26 N.J.R. 2214(a)		
19:45-1.1, 1.41A	Removal of coin, slot tokens and slugs from slot machines	26 N.J.R. 1620(a)	R.1994 d.423	26 N.J.R. 3465(a)
19:45-1.17, 1.42	Temporary storage of slot cash storage boxes and slot drop boxes	26 N.J.R. 2213(a)	R.1994 d.422	26 N.J.R. 3464(a)
19:45-1.24A	Wire transfer fees	26 N.J.R. 2215(a)		
19:45-1.25	Exchange of counter checks	26 N.J.R. 1994(a)		
19:45-1.25	Repurchase of cash equivalents by patrons	26 N.J.R. 2216(a)		
19:45-1.36	Recording of bill changer entries	26 N.J.R. 2217(a)		
19:45-1.40B	Temporary investment of annuity jackpot trust funds	26 N.J.R. 1996(a)	R.1994 d.405	26 N.J.R. 3187(c)
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