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(Includes adopted rules filed through December 11, 1991)

MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: OCTOBER 21, 1991
See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT NOVEMBER 18, 1991

RULEMAKING IN THIS ISSUE

RULE PROPOSALS

RULE ADOPTIONS

(Continued on Next Page)

INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **February 5, 1992.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal or group of proposals.

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.

RULEMAKING IN THIS ISSUE—Continued

PUBLIC NOTICES

Filing Deadlines

February 3 issue:	
Adoptions	**January 10**
February 18 issue:	
Proposals	**January 16**
Adoptions	**January 24**
March 2 issue:	
Proposals	**January 30**
Adoptions	**February 6**
March 16 issue:	
Proposals	**February 14**
Adoptions	**February 24**

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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RULE PROPOSALS

BANKING

(a)

OFFICE OF REGULATORY AFFAIRS

Notice of Extension of Comment Periods:

(1) Mortgage of Processing Rules, N.J.A.C. 3:1-16
Proposed: September 3, 1991 at 23 N.J.R. 2613(b)

(2) Reporting of Crimes Rules, N.J.A.C. 3:6-4.5 and 4.6, and 3:26-3.1 and 3.2
Proposed: October 7, 1991 at 23 N.J.R. 2903(a)

(3) Low-Income Credit Union Rules, N.J.A.C. 3:21
Proposed: October 7, 1991 at 23 N.J.R. 2905(a)

Take notice that the Department of Banking has extended the comment period until January 12, 1992 for the above captioned proposals in order that proper secondary notice may be provided.

Submit comments by January 12, 1992 to:
Robert M. Jaworski, Assistant Commissioner
Office of Regulatory Affairs
Department of Banking
20 West State Street, CN 040
Trenton, New Jersey 08625

COMMUNITY AFFAIRS

(b)

DIVISION OF HOUSING AND DEVELOPMENT

Continuing Care Retirement Community Rules
Civil Penalties

Proposed Amendments: N.J.A.C. 5:19-2.12 and 9.3

Authorized By: Melvin R. Primas, Jr., Commissioner, Department of Community Affairs.
Authority: N.J.S.A. 52:27D-351 and 358.
Proposal Number: PRN 1992-9.

Submit written comments by February 5, 1992 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, New Jersey 08625

The agency proposal follows:

Summary

P.L. 1991, c.314, signed by Governor Florio on November 14, 1991, amended the Continuing Care Retirement Community Regulation and Financial Disclosure Act, P.L. 1986, c.103, so as to authorize the Department of Community Affairs to levy and collect civil penalties of between $250.00 and $50,000 for violations of the Act or of any rule adopted thereunder. The amendment also required the Commissioner of Community Affairs to adopt administrative rules regarding the implementation of the new civil penalty provision. These rules provide that the initial penalty levied shall not exceed $250.00 per violation, or $250.00 per unit, up to the statutory maximum of $50,000, in the case of any establishment, operation or administration of a facility without obtaining and maintaining a certificate of authority. Subsequent penalties for each violation shall not exceed 10 times the amount of the last previous penalty imposed for the same violation or the statutory maximum, whichever is less. These limitations shall not apply to any violation involving either dishonesty in dealings with residents or prospective residents or willful disregard of the rights of residents.

A correction is also made to the mailing address for hearing requests, at N.J.A.C. 5:19-9.3.

Social Impact

The proposed amendment to N.J.A.C. 5:19-2.12 sets forth the general criteria that will be used by the Department in levying penalties and should allay concerns among providers that the new penalty authority will be exercised in an arbitrary fashion.

Economic Impact

By making clear the Department's policy concerning the levying of penalties, the amendment allows providers to better evaluate the likely economic consequences to them of any failure to comply with the statute, the rules or any order of the Department issued thereunder.

Regulatory Flexibility Analysis

Most, if not all, continuing care providers qualify as "small businesses" under the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The proportionate penalties, based on facility size, for establishment, operation or administration of a facility without a certificate of authority provide protection for owners of smaller facilities, who are most likely to be "small businesses," against unfair treatment. Even if some providers were "small businesses" and others were not, all are equally obligated to conduct their affairs honestly in accordance with the Act. Therefore, no differentiation based upon business size has been provided in the rules.

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

5:19-2.12 Cease and desist orders; injunctions; **civil penalties**

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

(d) In addition to, or in lieu of, the actions authorized by (a) through (c) above, the Department may levy and collect civil penalties in the amount of not less than $250.00, and not more than $50,000.00, for each violation of the Act or of this chapter, or of any order issued thereunder, and may compromise and settle any claim for a penalty in such amount as in the discretion of the Department may appear appropriate and equitable under the circumstances of the violation.

1. Each day during which a violation continues after the effective date of a notice to terminate issued by the Department shall constitute an additional, separate and distinct violation.

2. Except as set forth in (d)3 below, the initial penalty levied for any violation shall not exceed $250.00 per violation, or $250.00 per unit in the case of any violation of N.J.A.C. 5:19-2.1, and a subsequent penalty for the same act or omission shall not exceed 10 times the amount of the last previous penalty or the statutory maximum, whichever is less.

3. The limitations set forth in (d)2 above shall not apply to any violation involving either dishonesty in dealings with residents or prospective residents or willful disregard of the rights of residence.

4. If an administrative order levying a civil penalty is not satisfied within 30 days of its issuance, the Department may sue for and recover the penalty with costs in a summary proceeding under N.J.S.A. 2A:58-1 et seq. in the Superior Court.

5:19-9.3 Rights to a hearing

Any applicant aggrieved by an order or determination of the Department issued under these rules shall be entitled to a hearing as provided by law, provided a written request for such hearing is filed within 20 days of the receipt of the order or determination. Hearing requests shall be addressed to the Hearing Coordinator, Division of Housing and Development, CN [804]**802**, Trenton, New Jersey 08625.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code Administration and Enforcement

Proposed Amendments: N.J.A.C. 5:23-2.1 and 2.15.

Authorized By: Melvin R. Primas, Jr., Commissioner, Department of Community Affairs.
Authority: N.J.S.A. 52:27D-124.
Proposal Number: PRN 1992-1.

Submit comments by February 5, 1992 to:
Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, NJ 08625
FAX Number (609) 633-6729

The agency proposal follows:

Summary

Section 21 of the State Uniform Construction Code Act (N.J.S.A. 52:27D-139) provides, in part, that "nothing contained in this act or the code shall be deemed to affect, repeal or invalidate ... the regulation or licensing of any trade or profession engaged in construction work."

Nevertheless, there has been confusion about the effect of various laws outside the Uniform Construction Code Act, notably the laws defining the respective jurisdictions of the Board of Master Plumbers and the Board of Examiners of Electrical Contractors, on the duties of code enforcement officials, and this has led to some practical and legal disputes. Some persons, for example, have contended that all work governed by the plumbing subcode must be performed by licensed plumbers. This is not the case, since the scope of the code is broader than the scope of the relevant licensing law. Jurisdictional questions of this kind should be resolved by the appropriate professional licensing board and, if necessary, by the courts, but not by this Department or its licensed code enforcement officials. Accordingly, the Department is reiterating the scope of its authority in this regard and is making clear the obligation of its licensees to refer any cases that might require a determination as to the need for licensing to the appropriate professional board.

Social Impact

These proposed amendments will remove the Department and code enforcement officials from direct involvement in disputes regarding alleged violation of professional licensing laws. Code enforcement officials and inspectors will continue to carry out their duty to ensure that all work is done in accordance with the code, the applicable subcode and all referenced standards. Any violations of professional licensing laws will continue to be addressed by the boards having jurisdiction, which will continue to have the cooperation of the Department and its licensees.

Economic Impact

By making it clear that the adopted subcodes do not determine the scope of work for which licensing is required, these amendments should eliminate the possibility of litigation resulting from varying opinions as to how the Uniform Construction Code and the licensing statutes interrelate.

Regulatory Flexibility Statement

Because the proposed amendments impose no additional requirements on businesses of any size, they should have no differential impact on large and small businesses. The amendments clarify the respective responsibilities of the trade or profession licensing boards and the Department regarding the enforcement of their respective laws and codes.

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

5:23-2.1 Title; scope; intent

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

(e) Nothing contained in these rules or in any adopted subcode shall be deemed to affect the regulation or licensing of any trade or profession engaged in construction work or to define the scope of work for which any such licensing is required. Where a statute or an ordinance requires a person to hold a license in order to perform any specific element of work, then the determination of whether or not a license is required in a particular situation shall be made by the official or agency responsible for the enforcement of the licensing statute or ordinance and not by any official responsible for the enforcement of these rules or any adopted subcode.

5:23-2.15 Construction permits—application

(a) (No change.)

(b) In addition, the following information shall be required on any application for a construction permit when such information is available, but not later than the commencement of work[.]**:**

1.(No change.)

2. The name and license number of [the] **any** contractor or subcontractor for plumbing [and for] **or** electrical work, where such work is proposed.

i. Plumbing and electrical work shall not be undertaken except by persons licensed to perform such work pursuant to law, except in the case of:

(1) [a] **A** single family homeowner **performing work** on his own dwelling **or**

(2) [any] **Any other person not required by law to be licensed in order to undertake the specific work.**

ii. The seal and signature of the licensed plumbing [and] **or** electrical contractor shall be affixed to the corresponding subcode application form.

iii. In the event of any uncertainty on the part of the construction official as to whether an unlicensed person is required by law to be licensed in order to undertake any proposed plumbing or electrical work, the construction official shall issue the permit, but shall also submit a copy of the plumbing or electrical subcode application form to the professional board having jurisdiction for such action as that board may deem appropriate.

(c)-(e) (No change.)

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

DIVISION OF FISH, GAME AND WILDLIFE

Weakfish Management
Notice of Withdrawal of Proposal

Take notice that the Department of Environmental Protection and Energy (Department) has withdrawn the proposed amendment and new rules concerning weakfish management, published on July 1, 1991 at 23 N.J.R. 1989(b).

The Department received substantial public comment opposing the proposed amendment and new rules. In response to those comments, the Department has developed an alternative method to protect and manage weakfish populations which addresses the commenter's concerns. That alternative is set forth in a new proposal published in this issue of the New Jersey Register.

(c)

DIVISION OF FISH, GAME AND WILDLIFE

Marine Fisheries
Weakfish Management

Proposed Amendments: N.J.A.C. 7:25-18.1 and 18.5
Proposed New Rule: N.J.A.C. 7:25-18.12

Authorized By: Scott A. Weiner, Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 23:2B-6.
DEPE Docket Number: 049-91-12.
Proposal Number: PRN 1992-23.

A **public hearing** on the proposal will be held on Tuesday, January 21, 1992, 7:00 P.M. at:

Stockton State College
A Wing Lecture Hall
Pomona, NJ 08240

Submit written comments by February 5, 1992 to:

Samuel A. Wolfe, Esq.
Office of Legal Affairs
Department of Environmental Protection and Energy
CN 402
Trenton, NJ 08625

The agency proposal follows:

Summary

On July 1, 1991 the Department published a proposal on weakfish management in the New Jersey Register at 23 N.J.R. 1989(b). The proposal included a provision to establish an individual quota system for all commercial fishermen with the exception of the otter trawl fishery. A significant amount of comment was received expressing concern that accurate information upon which to base a quota system was not available. The Department agreed with those comments and has developed an alternative proposal which does not include the individual quota system. This proposal supersedes the July 1, 1991 proposal.

The weakfish resource has exhibited a significant decline during the last few years. A comparison of total landings (both recreational and commercial) between the periods 1983-1987 and 1988-1989 reveal a dramatic decline. Average landings during the 1988-1989 period reflect a 63 percent reduction over average landings during the period 1983-1987. Similar declines have been seen in other coastal states. During the last few years there has been a coastwide attempt to develop compatible management measures for weakfish throughout its range from Florida to Massachusetts.

The purpose of these proposed amendments and new rule is to implement the recommendations of the Atlantic States Marine Fisheries Commission (ASMFC) addressing the aforementioned decline by protecting and managing weakfish populations in New Jersey as part of a coastwide weakfish management plan. The plan calls for the member states to reduce exploitation on weakfish by 25 percent for the next three years. New Jersey submitted their plan for review in the fall of 1991 and received ASMFC approval.

The Department proposes to implement its ASMFC approved plan by the use of minimum size limits, daily possession limits, mesh restrictions and seasonal closures. To place the burden of management equitably upon all user groups, the weakfish fishery was broken down into three specific components including recreational hook and line, commercial otter trawl and all other commercial methods (gill nets, pound nets). Based upon the best information available, various management options were developed for each component of the weakfish fishery.

A 25 percent reduction can best be achieved for the recreational hook and line fishery by implementing a 13-inch minimum size limit in combination with a 10-fish per angler per day possession limit. The reduction in the otter trawl fishery can best be obtained by implementation of an 11-inch minimum size limit accompanied by a three inch minimum mesh size in the cod end of the net. The gill net component can be best reduced by the implementation of a 13-inch minimum size limit, a 3¼ inch minimum stretched mesh for gill nets and seasonal closures. A spring closure would primarily limit the harvest of weakfish in the Delaware Bay gill net fishery while a fall closure would restrict harvest activity in the ocean gill net fishery. During the spring closure the use of gill nets in Delaware Bay, with a few exceptions, would be prohibited. This provision is necessary to reduce the potential bycatch of weakfish that could otherwise occur. The proposal also calls for the implementation of a delayed entry system for the gill net fishery. This system would require an individual to be on a waiting list for gill net licenses for two years before being eligible for a license unless he had a gill net license in 1990 or 1991.

As a means to enforce the seasonal closures, a total prohibition on the sale of weakfish in New Jersey would be imposed during the spring closure. In addition, there would be a prohibition on the sale of weakfish during the fall closure, with the exception of the otter trawl fishery which primarily operates during this time of year.

Under the proposal, the Commissioner may modify the otter trawl mesh size and the seasonal closures by notice in the New Jersey Register in order to expeditiously respond to the needs of the resource, as more scientific information is developed or as the resource dynamics dictate.

The management options described above would reduce the fishing pressure on the weakfish resource and enhance conditions for recovery of the stock.

Social Impact

The proposed amendments and new rules are designed to implement a management program for weakfish. An immediate goal of this management program would be to reduce fishing mortality by 25 percent uniformly across all segments of the fishery.

To reduce the recreational fishery by 25 percent will require the imposition of a 13-inch minimum size limit and a 10-fish possession limit. Since neither size nor possession limits have previously existed for this species, there will be some social impacts as anglers adjust to these restrictions. A 12-inch minimum size limit with a six-fish possession limit was initially suggested as the means of achieving a 25 percent reduction in recreational harvest. However, Delaware Bay party and charter boat captains objected to the six-fish possession limit believing that it would seriously reduce the number of customers. Representatives from recreational fishing clubs in the area also objected to the six-fish daily possession limit. They suggested a larger size limit so the daily possession limit could be more liberal. The proposed amendments and new rule, as written, should reduce this resistance and be much more socially acceptable to the recreational fishermen.

There is concern that commercial fishermen may experience a loss of their market for weakfish during the closed season to out-of-State suppliers who may not be subject to similar restrictions and could, therefore, fill the void in New Jersey markets. In an effort to prevent this from occurring, the proposed new rule has provisions to prevent the sale of weakfish in New Jersey during the closed seasons. This action should preserve the markets for New Jersey fishermen. In addition, the no sale provision greatly enhances the Department's ability to enforce the seasonal closures.

The provision to prohibit gill netting in Delaware Bay during the spring closed season does present a minimal adverse social impact. A total ban on gill netting during this period would have prevented other fisheries from operating. In order to minimize this impact, exceptions have been incorporated into the rules that would allow important commercial fisheries to continue during the closed season, while still reducing the potential of large scale weakfish bycatch.

The 13-inch minimum size limit and 3¼ inch gill net mesh should have virtually no social impact on the weakfish fishermen. Most gill netters targeting weakfish currently utilize a mesh of 3¼ inches or greater and sampling data indicate that few weakfish harvested by gill nets are less than 13 inches. Exceptions to the minimum mesh of 3¼ inches have been included in the rules so as to permit traditional fisheries in Delaware Bay to continue. The proposed delayed entry system into the gill net fishery will have an adverse social impact on individuals not currently in the fishery. Anyone interested in becoming a gill net fishermen will have to plan ahead. The delayed entry system is designed to prevent the opportunistic fishermen from jumping into the gill net fishery whenever there is an increase of available fish, keeping stocks depressed to the detriment of traditional full time gill netters and baymen. Thus, this aspect of the rules will have positive social and economic impacts for fishermen currently in the gill net fishery that depend on this fishery for their livelihood and is being proposed to reduce the adverse social and economic impacts on these fishermen.

The 11-inch minimum size limit for the otter trawl fishery and the three-inch mesh in the cod end of the net is being proposed to reduce the social impact on this fishery. Originally a 12-inch minimum size and a 3½ inch minimum mesh had been suggested. However, a mesh assessment study recently conducted with otter trawl vessels has indicated that there were few larger weakfish available to the otter trawl vessels this year. Thus, the 11-inch minimum size limit would fulfill the 25 percent reduction for this component of the weakfish fishery. An 11-inch size limit would also put New Jersey's otter trawl fishery more in line with the otter trawl fisheries of the states to the south, with whom they compete.

Overall the Department does not anticipate any significant adverse social impacts from the implementation of these amendments and new rule.

Economic Impact

Anytime the harvest of an important recreational and commercial species is reduced, there is bound to be at least a temporary economic

impact. The purpose of these rules is to manage the weakfish resource by stopping the recent decline of weakfish and restoring the population, over time, to prior abundance. The short term economic loss brought about by harvest restrictions will be more than offset by improvement in stock conditions in the long term with resultant economic increases in the recreational and commercial fisheries.

The recreational fishery, especially the charter and party boat fisheries in the Delaware Bay area, have suffered significant loss of income over the past several years due to the recent decrease in weakfish stock size. The proposed amendments and new rule may temporarily add somewhat to this problem. However, the change in the original position from a 12-inch size limit and six-fish possession limit to a 13-inch size limit and 10-fish possession limit, as discussed in the Social Impact, should reduce the potential economic impact of this regulation in the recreational fishery to acceptable levels.

During the period between 1988 and 1990, the annual otter trawl weakfish landings in New Jersey averaged 1.2 million pounds with an average dockside value of $342,742. The vessels engaged in the otter trawl fishery harvest a multitude of species in addition to weakfish. In the same three year period, the otter trawl fishery accounted for annual average landings in excess of 37 million pounds with a comparable average annual value of $14 million. These figures indicate that the weakfish harvest represented only 2.7 percent by weight and 2.4 percent by value of the fish landed by otter trawl vessels on the annual average over the last three years. The lower size limit (11 inches) for this fishery permits New Jersey otter trawlers to compete with other trawlers to the south who will most likely also have a size limit less than 12 inches. Some otter trawl vessels may be required to purchase new nets (approximately $1,000 a piece) to comply with the minimum mesh sizes. Although there will be a reduction in the amount of weakfish landed by otter trawl, it does not represent a significant adverse economic impact to the otter trawl fishery as a whole.

The gill net fishery accounted for average annual landings of 829,603 pounds with an equivalent value of $421,473 during the last three years (1988-1990). Weakfish represent a significant portion (60 percent) of all species landed by gill net. This fishery is pursued by about 400 fishermen. The majority of these individuals are part time gill netters. During the fishing season they may also fish for crabs, shellfish and eels, or may even pursue land-based jobs. Provisions of the amendments and new rule (no sale during closed season, delayed entry, exception to mesh size, exceptions to net prohibition in Delaware during season closure) are all designed to permit traditional fisheries to continue and to preserve the fishermen's market so as to minimize the adverse economic impacts to this segment of the weakfish fishery. Although the delayed entry provision may "delay" income to someone currently not in the gill net fishery, it is only proper to help those that have sacrificed something now when conditions improve. Those not involved in the fishery, at this time, have no time or capital investments in jeopardy by being delayed entry into the fishery.

Although there will be some obvious short term adverse economic impacts to all users of the weakfish resource, the Department has designed the amendments and new rule so no one user group receives a disproportionate share of the burden. The weakfish stocks are in a decline and to ignore this problem any longer could result in disastrous economic impacts to all user groups in the near future. By addressing the issue now, the potential exists to facilitate recovery of the weakfish resource. This, in turn, will result in increase economic benefits to those involved. The Department has determined that any short term, adverse economic impacts that occur as a result of the amendments and new rule are necessary if the stock is to recover with the resultant long term positive economic gain.

Environmental Impact

As indicated in the Summary, the weakfish resource has been declining from levels of the mid 1980's. The proposed amendments and new rule are expected to have a positive environmental impact on the weakfish resource. The ASMFC has recommended that fishing mortality be reduced by 25 percent for each coastal state to give the weakfish resource the opportunity to recover. The amendments and new rule have been approved by the ASMFC as fulfilling the requirements of a 25 percent reduction.

One aspect of the ASMFC recommendation is to maintain a spawning stock large enough to minimize recruitment failure and increasing yield per recruit by delaying their entry into the fishery to ages greater than one. The 13-inch minimum size limit will help achieve these goals. Most weakfish are sexually mature at 12 inches and will thus have the opportunity to spawn prior to being available for harvest. Although the otter trawl size limit is below the preferred 12 inch size, the three-inch mesh cod end will permit a significant number of smaller (less than 11 inches) fish to escape through the net, thus reducing mortality of juvenile fish.

The Department anticipates a significant positive environmental impact on the weakfish resource as a result of the proposed amendment and new rule.

Regulatory Flexibility Analysis

The proposed amendments and new rule would apply to all recreational and commercial fishermen and party and charter boats fishing for weakfish and fish dealers. Most of the commercial fishermen, party and charter boats, and fish dealers are small businesses as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and may be impacted to some degree, as discussed above. Although these small businesses will have to comply with the requirements of the rules, it is unlikely that additional professional services or significant capital costs will be required for compliance. In developing the amendments and new rule, the Department has balanced its environmental responsibilities against the economic impact to small businesses and has determined that to minimize the impact of the amendment would adversely affect the environment, and eventually these same small businesses and, therefore, no exemption from coverage is provided.

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

7:25-18.1 Size and possession limits

(a) A person shall not purchase, sell, offer for sale, or expose for sale any sea sturgeon measuring less than 42 inches in length, codfish measuring less than 12 inches in length, bluefish [or weakfish] measuring less than nine inches in length, sea bass or kingfish measuring less than eight inches in length, or blackfish, mackerel or porgy measuring less than seven inches in length.

(b) A person shall not take from the marine waters in the State or have in his possession any summer flounder, commonly called fluke, under 13 inches in length, winter flounder under 10 inches in length, [or] red drum under 14 inches in length, **or weakfish under 13 inches in length except as provided in N.J.A.C. 7:25-18.12.**

(c)-(o) (No change.)

7:25-18.5 General net regulations

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

(g) Individuals intending to take fish with a net in the marine waters of this State pursuant to N.J.S.A. 23:5-24.2 shall, as required, apply to the Commissioner for a license and/or permit. **To be eligible to purchase a license for a drifting, staked or anchored gill net, the applicant shall have purchased a gill net license during 1990 or 1991 or provide documented proof of active military service within one year of application. An applicant who does not meet the above requirements must file an application, in person, with the Department in each of two consecutive years during the month of January. Such an applicant shall be eligible for gill net licenses in the following calendar year. Availability of Delaware Bay Gill Net Permits shall be determined pursuant to N.J.A.C. 7:25-18.6 through 18.11.** Upon receipt of the application, and the prescribed license fee, the Commissioner may, in his or her discretion, issue single season licenses and/or permits as specified for each net type for the taking of fish with nets only as follows:

1.-4. (No change.)

5. Drifting gill nets shall be used only in the Atlantic Ocean, Delaware Bay, and the tributaries of Delaware Bay. The smallest mesh of any drifting gill net shall be not less than five inches stretched beginning February 12 through February 29 and not less than [2.75] **3.25** inches stretched beginning March 1 through December 15 **except in the tributaries of Delaware Bay and in Delaware Bay within two nautical miles of the mean high water line where the smallest mesh shall be not less than 2.75 inches stretched.** These nets shall not individually exceed 200 fathoms in length. Individual drifting gill nets shall not be fastened together to form a series of nets exceeding 400 fathoms in length beginning February 12 through

May 15 or exceeding 200 fathoms in length beginning May 16 through December 15. Drifting gill nets may be used for all species except those specifically protected.

i.-iv. (No change.)

v. Drifting gill nets shall be used in Delaware Bay only from February 12 through December 15, **subject to the additional conditions specified in N.J.A.C. 7:25-18.12**. For the purpose of this section, that portion of Delaware Bay defined by the New Jersey-Delaware boundary on the west, Loran C27180 on the east, and Loran C42830 on the north, during the period from May 15 through June 15, shall be known as the Brandywine Shoal Restricted Area.

(1)-(2) (No change.)

vi. (No change.)

6. Staked and anchored gill nets shall be used only in the Atlantic Ocean, Raritan Bay, Sandy Hook Bay, and the Delaware Bay and its tributaries. Staked or anchored gill nets shall not be fastened together to form a series of nets exceeding 400 fathoms in length from the beginning of the season through May 15 or exceeding 200 fathoms in length beginning May 16 through December 15, **subject to the additional conditions specified in N.J.A.C. 7:25-18.12.**

i.-ii. (No change.)

iii. Staked and anchored gill nets may be used in the Atlantic Ocean for any species except those specifically protected only beginning February 12 through December 15, where individual gill net length shall not exceed 50 fathoms. The smallest mesh of any such net used in the Atlantic Ocean shall not be less than five inches stretched beginning February 12 through February 29 and not less than [2.75] **3.25** inches stretched beginning March 1 through December 15. Staked or anchored gill nets shall not be used in the Atlantic Ocean within 100 fathoms of the marked channel of any inlet;

iv.-v. (No change.)

vi. Staked gill nets may be used in Delaware Bay [for any species except those specifically protected] only [beginning] **from** February 1 through December 15, **except as further limited by statute and/or rule.** [where individual] **Individual staked** gill net length shall not exceed 30 fathoms. The mesh of any such net used in Delaware Bay shall be 2.75 inches stretched beginning February 1 through February 29 and shall not be less than [2.75] **3.25** inches beginning March 1 through December 15, **subject to the additional conditions specified in N.J.A.C. 7:25-18.12**. Staked gill nets shall not be used in that portion of Delaware Bay known as the Brandywine Shoal Restricted Area as defined in (g)5v above;

vii. (No change.)

viii. The use of anchored gill nets is permitted in the Delaware Bay [for any species except those specifically protected] only [beginning] **from** February 12 through December 15, **except as further limited by statute and/or rule.** [where individual] **Individual anchored** gill net length shall not exceed 30 fathoms. The smallest mesh of any such net used in the Delaware Bay shall not be less than five inches stretched beginning February 12 through February 29 and not less than [2.75] **3.25** inches from March 1 through December 15 **and subject to the additional conditions specified in N.J.A.C. 7:25-18.12**. Anchored gill nets shall not be used in that portion of the Delaware Bay known as the Brandywine Shoal Restricted Area as defined in (g)5v above;

ix. (No change.)

7.-12. (No change.)

(h) (No change.)

7:25-18.12 Weakfish management

(a) A person shall not possess any weakfish less than 13 inches in length; provided, however, a person may possess a weakfish that was harvested by otter trawl and that measures not less than 11 inches in length from September 1 through December 31.

(b) A person angling with hand line or with rod and line shall not possess more than ten weakfish at any time. Possession of hand line or rod and line with more than 10 weakfish shall be prima facie evidence of violation of this section.

(c) A person shall not remove the head, tail or skin or otherwise mutilate to the extent that its length or species cannot be determined any weakfish, except after such weakfish has been landed to any ramp, pier, wharf, dock or other shore structure where it may be inspected for compliance with the appropriate size limits, except that weakfish fillets with the skin attached may be landed provided they are not less than the minimum size specified at N.J.A.C. 7:25-18.1(b) and at (a) above.

(d) Any person violating the provisions of (a), (b) or (c) above shall be liable to a penalty of $20.00 for each fish taken or possessed. Each fish taken or possessed shall constitute an additional separate and distinct offense.

(e) A person shall not take, or attempt to take, any weakfish by any means other than angling, and a person shall not possess more than ten weakfish, during the closed seasons beginning June 7 through June 30 and October 20 through December 31 except as provided in (g) and (i) below. The Commissioner may modify the closed seasons specified above upon notice provided the spring closure established is between May 15 and June 30 and the fall closure established is between October 1 and December 31. The Department shall provide notice of any change by filing and publishing in the New Jersey Register. All such notices shall be effective when the Department files notice with the Office of Administrative Law or as specified otherwise in the notice.

(f) A person shall not set, tend, or attempt to set or tend a drifting, staked or anchored gill net in Delaware Bay during the spring closed season specified in (e) above or as modified by the Commissioner by notice except as follows:

1. The use of drifting, staked or anchored nets with a stretched mesh not less than 10 inches is permitted;

2. The use of drifting, staked or anchored nets with a stretched mesh not less than 5.5 inches is permitted south of Loran C42800;

3. The use of drifting, staked or anchored nets with a stretched mesh not less than 2.75 inches or greater than 3.0 inches is permitted in Delaware Bay within two nautical miles of the mean high water line.

(g) A person shall not sell, barter, possess for sale or barter, or offer for sale or barter any weakfish during the closed seasons specified in (e) above, or as modified by the Commissioner, except for:

1. Weakfish harvested by otter trawl during the fall closure;

2. The wholesale or retail sale of fresh weakfish by fish dealers within seven days of the beginning of the spring closure; or

3. Frozen weakfish.

(h) Possession of greater than 10 weakfish at any time during the closed seasons shall be prima facie evidence of violation of the no sale provision (g) above.

(i) The following provisions shall apply to the use of otter or beam trawls for the taking of weakfish;

1. The possession of at least 100 pounds of weakfish on board a vessel or landed from a vessel shall constitute a directed fishery for weakfish.

2. A person utilizing an otter or beam trawl in a directed fishery for weakfish shall not use a net of less than 3.0 inches stretched mesh inside measurement applied throughout the cod end for at least 75 continuous meshes forward of the terminus of the net. The Commissioner may modify the mesh size, by notice as specified in (e) above, if more current scientific data indicate a more appropriate size. The possession of any net less than the minimum mesh specified above in this paragraph, or as modified by the Commissioner, on board a vessel in a directed fishery for weakfish is prohibited.

3. The procedures for determining compliance with the minimum mesh size and enforcement of this subsection shall be consistent with procedures prescribed pursuant to N.J.A.C. 7:25-18.1(c)2, 3, 5 and 6.

HIGHER EDUCATION

(a)

STUDENT ASSISTANCE BOARD

Paul Douglas Teacher Scholarship Program Rules Incorporated by Reference; Definitions; Attendance in an Eligible Institution; Renewal of Scholarship Eligibility

Proposed Amendments: N.J.A.C. 9:7-9.1, 9.2, 9.4 and 9.8

Authorized By: Student Assistance Board, M. Wilma Harris, Chairperson.

Authority: N.J.S.A. 18A:71-15.3, Title V, Part E of the Higher Education Act of 1965, as amended by the Human Services Reauthorization Act of 1984, 20 U.S.C. 1119d-8 and the Higher Education Technical Amendments Act of 1987.

Proposal Number: PRN 1992-8.

Submit comments by February 5, 1992 to:

Brett E. Lief
Acting Administrative Practice Officer
Department of Higher Education
20 West State Street
CN 542
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendments to N.J.A.C. 9:7-9 delete the eligibility restriction that students must be enrolled or plan to enroll in an accredited college or university located only within New Jersey in order to participate in the Paul Douglas Teacher Scholarship Program (PDTSP). This program, which is Federally funded, is administered by the New Jersey Department of Higher Education and was created to encourage highly qualified students to pursue teaching careers at the preschool, elementary or secondary school levels by providing financial assistance for postsecondary education leading to teacher certification. The initial participation agreement and ensuing letters of intent included the criterion that restricted eligibility to in-State enrollment and, as such, were approved by the U.S. Department of Education (USDE). As a result, rules incorporating this criterion for the administration of the PDTSP were noticed in the New Jersey Register and subsequently adopted by the Student Assistance Board.

However, in August of 1991 notification was received from the Acting Chief of the State Grant Section in the USDE which identified New Jersey's previously approved in-State eligibility restriction for the PDTSP as now being inconsistent with Federal program requirements and, as such, not legally authorized. Therefore, it must be deleted from New Jersey's program documents, application and rules.

In consulting the State Attorney General's Office, the Department of Higher Education was informed that Federal rules take legal precedence over State rules and in view of the USDE's newly received interpretation, the Department must rescind the in-State eligibility restriction. In addition, the proposed amendments also adhere to the Attorney General's recommendation that the applicable Federal statutes and rules be incorporated by reference in the State rules so that any future changes to the PDTSP Federal requirements are automatically mirrored in the Administrative Code. Also, the format of N.J.A.C. 9:7-9.2, Definitions, is revised to that currently used in the Code, and cross-references in the "alternative route" definition to Department of Education rules are corrected to reflect recodification by that Department.

Social Impact

Under current rules for the Paul Douglas Teacher Scholarship Program, students must attend an accredited college or university located within New Jersey in order to qualify for financial assistance in pursuing their postsecondary education towards teacher certification. In order to align State rules governing the program with Federal requirements, the proposed amendments will eliminate the eligibility restriction of attending an in-State institution and will now allow students to enroll or be enrolled in any college or university that is currently accredited by a nationally recognized accrediting agency or association that the Secretary of Education determines to be a reliable authority regarding the quality of training offered.

Economic Impact

The proposed amendments will not affect the current maximum annual award amount of $5,000 for which students may qualify under the Paul Douglas Teacher Scholarship Program. Eligible students may now utilize their awards to help finance their postsecondary education at any accredited college or university. The number of awards granted to qualified students within an academic year will continue to remain within the limits of Federal funding for the 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. 52:14B-16 et seq. The proposed amendments eliminate the in-State eligibility enrollment restriction in order that State rules governing the Paul Douglas Teacher Scholarship program may be consistent with Federal requirements.

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

9:7-9.1 Rules and **statutes** incorporated by reference

(a) The part of the Code of Federal Regulations known as 34 C.F.R. 653 through and including 34 C.F.R. 653.42 (as of November 25, 1987) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within this subchapter.

(b) The part of the United States Code known as Title 20, Chapter 28, Subchapter IV, Part D, 20 U.S.C. 1111 (as of October 17, 1986) including all subsequent amendments and supplements is hereby adopted as rules and incorporated within these regulations.

(c) The provisions of the following sections of subchapter 2 of this chapter, N.J.A.C. 9:7-2.2 residency, 2.3 foreign nationals, 2.11 payments, 2.14 check endorsements, 2.15 appeals and 2.16 accounting and auditing standards, governing the programs administered by the Student Assistance Board shall also apply to this program unless they are inconsistent with or otherwise excepted within the provisions of this subchapter.

9:7-9.2 Definitions

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

[(a)] "Alternate route" [shall] means the method of receiving approval from the New Jersey Department of Education to teach at the elementary or secondary school level pursuant to the provisions of N.J.A.C. 6:11-[5.3, 5.4, 5.5, 5.6 and 5.7] **5.1, 5.2, 5.3 and 5.4.**

(b) "Degree program leading to teacher certification" [shall] means an undergraduate teacher preparation degree program which curriculum leads to a recommendation for a [New Jersey] **state** instructional certificate awarded by [the New Jersey] **a state** Department of Education or any other undergraduate degree program in which the student enrolled has expressed the intention to utilize such degree for the purpose of securing a [New Jersey] **state** instructional certificate awarded by [the New Jersey] **a state** Department of Education, including any graduate study required to obtain an initial instructional certificate.

[(c)] "Installment promissory note" [shall] means the promissory note signed by the scholar which sets forth the specific terms of repayment of previously received scholarship monies and interest in lieu of reduction of scholarship balances through teaching service pursuant to N.J.A.C. 9:7-9.9.

[(d)] "Interim promissory note" [shall] means the promissory note signed by the scholar upon receipt of each disbursement of scholarship funds whereby the scholar promises to repay such funds plus interest unless teaching service is performed pursuant to N.J.A.C. 9:7-9.9.

9:7-9.4 Attendance in an eligible institution

An applicant must be enrolled or plan to enroll in an accredited [New Jersey] college or university on a full-time basis in a degree

program leading to a teaching certificate or has indicated an intent to seek employment in the teaching field through the "Alternate Route" method but not including graduate study that is not required for initial teacher certification.

9:7-9.8 Renewal of scholarship eligibility

(a) In order to maintain eligibility for a scholarship a scholar must be:

1. Enrolled as a full-time student in a [New Jersey] postsecondary institution that is currently accredited by a nationally recognized accrediting agency or association; and

2.-3. (No change.)

(b) (No change.)

INSURANCE

(a)

DIVISION OF FINANCIAL EXAMINATIONS AND LIQUIDATIONS

Surplus Lines Insurer Eligibility

Proposed New Rules: N.J.A.C. 11:1-31

Authorized By: Samuel F. Fortunato, Commissioner, Department of Insurance.

Authority: N.J.S.A. 17:1C-6(e), 17:1-8, 17:1-8.1 and 17:22-6.40 et seq.

Proposal Number: PRN 1992-24.

Submit comments by February 5, 1992 to:

Verice M. Mason
Assistant Commissioner
Legislative and Regulatory Affairs
Department of Insurance
CN 325
Trenton, New Jersey 08625

The agency proposal follows:

Summary

N.J.S.A. 17:22-6.45 provides that the Commissioner of Insurance (Commissioner) may make eligible as a surplus lines insurer an insurer which is not licensed to transact business in this State. Surplus lines insurers provide coverage which is generally not available from licensed insurers. N.J.S.A. 17:22-6.45 generally prohibits a surplus lines agent from placing coverage with an unauthorized insurer which is not an eligible surplus lines insurer.

Pursuant to the criteria for eligibility set forth in N.J.S.A. 17:22-6.45, the Department of Insurance (Department) developed filing requirements for unauthorized insurers seeking to become eligible surplus lines insurers. Upon review and approval of information that demonstrates compliance with the statutory criteria, the Commissioner issues a "Certificate of Eligibility" (Certificate) to the applicant.

The Department has determined to codify and clarify its filing requirements in these rules. This will ensure that the filing requirements for the issuance of a certificate are clearly stated and should streamline the application process. The proposed rules additionally reflect the application fee of $1,000 to cover the costs of Department review of the documents submitted as set forth in N.J.A.C. 11:1-32.7(a)1, increase current deposit requirements from the $200,000 to $500,000 or an amount equal to 25 percent of the applicant's outstanding loss reserves in New Jersey, whichever is greater; and impose the same deposit requirements on both foreign and alien applicants. In lieu of depositing securities in excess of $500,000, the applicant may, if a wholly-owned subsidiary, file an indemnity agreement subject to approval by the Commissioner by which its ultimate parent guarantees that it will discharge the subsidiary's obligations.

Proposed N.J.A.C. 11:1-31.1 sets forth the purpose and scope of the proposed new rules.

Proposed N.J.A.C. 11:1-31.2 sets forth the definition of terms used in the subchapter.

Proposed N.J.A.C. 11:1-31.3 provides the general requirements for an application for a certificate.

Proposed N.J.A.C. 11:1-31.4 sets forth the specific filing requirements for an application for a certificate.

Proposed N.J.A.C. 11:1-31.5 provides for the issuance of a certificate by the Commissioner.

Proposed N.J.A.C. 11:1-31.6 provides for the withdrawal of surplus lines eligibility under certain conditions.

Proposed N.J.A.C. 11:1-31.7 provides that failure to comply with these rules may result in the denial of a certificate.

Social Impact

The proposed new rules will ensure that the filing requirements for the issuance of a certificate are clearly and fully set forth. This should streamline the application process which, in turn, should benefit applicants. The Department will similarly benefit in that applicants will more likely submit complete filings.

In addition, these proposed new rules set forth the filing requirements from which the Department may determine whether an applicant's financial condition and methods of operation meet the criteria for eligibility in N.J.S.A. 17:22-6.45, which have been established by the Legislature for the protection of New Jersey policyholders.

Economic Impact

Applicants will be required to bear the costs associated with compiling and filing the required information. Since these filing requirements reflect current Department practice, little or no additional economic impact is imposed. Applicants will additionally be required to pay the $1,000 application fee to cover Department costs of reviewing the data submitted and deposit securities in the amount required by these rules. The Department believes, however, that any applicant whose financial condition is such that it meets the statutory minimum capital and surplus requirements should not be burdened by the application fee or additional deposit requirements.

Further, as was indicated in the Social Impact statement above, the filing requirements will enable the Department to determine whether an applicant's financial condition meets the statutory criteria for eligibility in N.J.S.A. 17:22-6.45.

Finally, most of the data to be filed is required by current Department practice. Therefore, no significant additional costs to the Department or to the applicant are imposed by these proposed new rules.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed new rules do not impose reporting, recordkeeping or other compliance requirements on "small businesses" as that term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These proposed rules apply to foreign and alien insurers only, and thus do not apply to businesses resident in this State.

Full text of the proposed new rules follows:

SUBCHAPTER 31. SURPLUS LINES INSURER ELIGIBILITY

11:1-31.1 Purpose and scope

(a) This subchapter sets forth the filing requirements and procedures for unauthorized insurers which seek to become eligible surplus lines insurers in this State in accordance with the Surplus Lines Law, N.J.S.A. 17:22-6.40 et seq.

(b) This subchapter applies to unauthorized insurers which seek to become eligible surplus lines insurers in this State.

11:1-31.2 Definitions

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

"Alien applicant" means an applicant which is an unauthorized insurer formed under the laws of any country other than the United States, its states, districts, territories, commonwealths, possessions or the Panama Canal Zone.

"Applicant" means an unauthorized foreign or alien insurer applying for a certificate of eligibility in this State.

"Certificate of eligibility" means a certificate issued to an unauthorized insurer by the Commissioner pursuant to N.J.S.A. 17:22-6.45 evidencing that it is an eligible surplus lines insurer in this State.

"Commissioner" means the Commissioner of the New Jersey Department of Insurance.

"Department" means the New Jersey Department of Insurance.

"Foreign applicant" means an applicant which is an unauthorized insurer formed under the laws of a jurisdiction of the United States other than this State.

"NAIC" means the National Association of Insurance Commissioners.

"Surplus lines agent" means a person licensed pursuant to N.J.S.A. 17:22A-1 et seq. and N.J.A.C. 11:17 with the authority to place insurance coverages on behalf of unauthorized insurers.

"Surplus lines insurer" means an unauthorized foreign or alien insurer in which an insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22-6.40 et seq.

"Unauthorized insurer" means a foreign or alien insurer that is not duly authorized to transact business in this State by a current certificate of authority issued pursuant to the laws of this State.

11:1-31.3 General requirements

(a) No surplus lines agent shall place any coverage in this State with any unauthorized insurer which is not an eligible surplus lines insurer in this State. No unauthorized insurer shall become an eligible surplus lines insurer unless made eligible by the Commissioner in accordance with N.J.S.A. 17:22-6.45 and this subchapter.

(b) No certificate of eligibility shall be issued to an applicant unless it demonstrates the following:

1. That it is either:

i. Currently authorized in its state or country of domicile as to the kind or kinds of insurance proposed to be so placed for not less than one year preceding the application for eligibility; or

ii. The subsidiary of an admitted insurer or eligible surplus lines insurer that has been admitted or eligible for not less than one year preceding the application for eligibility;

2. That it has capital and surplus, or its equivalent under the laws of its domiciliary jurisdiction, of not less than twice the amount of the minimum capital and surplus required by this State for like admitted insurers.

i. All applicants shall also submit a written commitment, signed by an officer of the applicant, that it will deposit with the Commissioner $500,000 or an amount equal to 25 percent of its outstanding loss reserves in New Jersey, whichever is greater, in trust for the benefit and security of all of its New Jersey policyholders and claimants not later than 60 days after the date of issuance of its certificate of eligibility.

ii. An alien applicant shall also maintain in the United States an irrevocable trust fund in a state or federally chartered bank in an amount not less than $2,500,000 for the protection of all of its policyholders in the United States. The trust fund shall conform to the requirements set forth in N.J.S.A. 17:22-6.45(d)(1).

iii. An insurance exchange created by laws of another state may be approved by the Commissioner as an eligible surplus lines insurer. Such an insurance exchange shall comply with the applicable financial requirements set forth in N.J.S.A. 17:22-6.45(d)(1) in addition to the requirements contained in this subchapter.

3. That it has complied with all of the requirements of N.J.S.A. 17:22-6.45 and this subchapter to entitle it to transact business as an eligible surplus lines insurer in this State;

4. That its condition or methods of operations are not such as would render its operation hazardous to the public or policyholders in this State;

5. That it is of good reputation as to providing service to the policyholders and the payment of losses and claims; and

6. That its management is not incompetent or untrustworthy, or so lacking in insurance company managerial experience as to make the proposed operation hazardous to the insurance buying public; and that it is not affiliated directly or indirectly through ownership, control, reinsurance transactions or other insurance or business relations, with any person or persons whose business operations are or have been detrimental to policyholders, stockholders, investors, creditors or to the public.

(c) All information submitted pursuant to this subchapter shall be sent to:

New Jersey Department of Insurance
Division of Financial Examinations and Liquidations
Attention: Surplus Lines Insurer Eligibility
CN-325
Trenton, New Jersey 08625-0325

11:1-31.4 Certificate of eligibility; filing requirements

(a) All applicants shall submit the following to the Commissioner:

1. A copy of the applicant's charter as currently in force, certified by the lawful custodian of the original document;

2. A copy of the applicant's bylaws as currently in force, certified by a senior officer of the applicant;

3. A certified copy of the applicant's current certificate of authority from the applicant's state or country of domicile;

4. A certified copy of a report of the most recent examination of the applicant's affairs by the department of insurance, or its equivalent, of the applicant's state or country of domicile;

5. An annual audited financial report conforming to the requirements of N.J.A.C. 11:2-26 or a certified copy of the applicant's most recent audited financial report required by the applicant's state or country of domicile which is substantially similar to the report required by N.J.A.C. 11:2-26;

6. Directors' and officers' biographical affidavits on a form provided by the Commissioner;

7. A statement of opinion by a qualified actuary, relating to the applicant's loss and loss adjustment expense reserves for all lines of business written by the applicant, containing the information required by N.J.A.C. 11:1-21;

8. A summary of the applicant's assumed and ceded reinsurance business, indicating the treaty parties, retentions, maximum risks, types of contract (that is, prorata, faculative, etc.) and any other information which may be relevant to the applicant's reinsurance portfolio;

9. If the applicant is a member of a holding company system, a certified copy of the information required by N.J.S.A. 17:27A-3 and the corresponding Securities and Exchange Commission requirements, including the names of all shareholders of record who control, either directly or indirectly, five percent or more of the applicant's outstanding shares;

10. A listing of all jurisdictions in which the applicant has applied for authorization to transact the business of insurance as a licensed insurer or surplus lines insurer during the preceding 10 years, including the dates and results of such application;

11. A listing of all jurisdictions from which the applicant has withdrawn during the preceding 10 years, including the reasons for withdrawal;

12. A listing of all administrative, civil or criminal actions, orders, proceedings and determinations thereof to which the applicant, its affiliates, or any of its directors or officers have been subject, due to an alleged violation of any law governing insurance operations in any jurisdiction during the preceding 10 years. Where the alleged violation is a felony or its equivalent, such criminal actions, orders, proceedings and determinations shall also include violations unrelated to insurance operations. If a license has been refused, suspended or revoked by any jurisdiction, the applicant shall furnish an explanation and a copy of any orders, proceedings and determinations related thereto;

13. A description of the applicant's present business plan or plans for conducting an insurance business, including, but not limited to:

i. The geographical areas in which the applicant currently conducts business;

ii. The kinds of insurance the applicant currently writes;

iii. The applicant's current marketing methods;

iv. A summary of the applicant's current methods for establishing premium rates; and

v. A description of agency systems, including any managing general agency contracts;

14. A proposed plan for conducting an insurance business in this State, including, but not limited to:

i. The geographical area in which the applicant intends to conduct business;

ii. The kinds of insurance the applicant intends to write;

iii. The applicant's proposed marketing methods;

iv. The applicant's proposed methods for the establishment of premium rates; and

v. A three year forecast of anticipated premiums in this State by line of business;

15. A certification signed by an officer of the applicant that it will comply with the following conditions for continued surplus lines eligibility upon being issued a certificate:

i. For all applicants:

(1) Annually file with the Department a statement of opinion by a qualified actuary relating to the applicant's loss and loss adjustment expense reserves for all lines of business written by the applicant which meets the requirements of N.J.A.C. 11:1-21, on or before June 30, (for foreign applicants) or on or before September 1 (for alien applicants) of each year;

(2) Except insurance exchanges, submit a non refundable, one time payment of $25,000 to the New Jersey Surplus Lines Insurance Guaranty Fund, pursuant to N.J.S.A. 17:22-6.75;

(3) Maintain a net premiums to surplus ratio for all jurisdictions of 3:1 or lower; and a gross premiums to surplus ratio for all jurisdictions of 6:1 or lower;

(4) Advise the Department in advance of any changes in the applicant's chief administrative officers, methods of operation, or assumed or ceded reinsurance agreements; and

(5) Deposit securities, as that term is defined in N.J.S.A. 17:20-1 and N.J.A.C. 11:2-32, with a minimum market value of $500,000 or in an amount equal to 25 percent of its outstanding loss reserves in New Jersey, whichever is greater, not later than 60 days after the effective date of its Certificate of Eligibility;

(A) The Commissioner may require an eligible surplus lines insurer to deposit additional securities in amount necessary to satisfy the standard set forth in (a)15i(5) above;

(B) If the applicant or eligible surplus lines insurer is a wholly-owned subsidiary and is required to deposit securities in excess of $500,000 pursuant to (a)15i(5) and (a)15i(5)(A) above, the applicant or eligible surplus lines insurer may, in lieu of such deposit, file with the Commissioner an indemnity agreement subject to approval by the Commissioner by which its ultimate parent guarantees that it will discharge the subsidiary's obligations in this State.

ii. For foreign applicants only:

(1) Annually file with the Department on or before March 1, a copy of its NAIC Annual Statement filed with its state of domicile for the year ended immediately preceding, and a copy of the report of any examination of the insurer during the year covered by the Annual Statement:

(2) File NAIC quarterly financial statements within 45 days after the end of each calendar quarter;

(3) Issue an insurance policy not later than 90 days after the effective date of the corresponding insurance placement; and

(4) Annually file with the Department on or before June 30 of each year, a copy of its annual audited financial report conforming to the requirements of N.J.A.C. 11:2-26 or a certified copy of the applicant's most recent audited financial report required by its domiciliary jurisdiction which is substantially similar to the report required by N.J.A.C. 11:2-26;

iii. For alien applicants only:

(1) Annually file with the Department on or before September 1, a copy of its audited financial statement; a report of its independent auditor, if any; and the Standard NAIIO Financial Format filed with the NAIC Non-admitted Insurers Information Office for the year ended December 31 immediately preceding; and

16. A written request, signed by a licensed surplus lines agent, that the Commissioner issue a Certificate of Eligibility to the applicant;

17. The application fee set forth in N.J.A.C. 11:1-32.7(a)1; and

18. Any additional information deemed necessary by the Commissioner to evaluate the applicant including, but not limited to, updated financial statements.

(b) Foreign applicants shall submit the following to the Commissioner in addition to the requirements in (a) above:

1. A certificate of compliance from its state of domicile;

2. Statements of the applicant's financial condition as of and for the two immediately preceding calendar years.

i. The annual statements shall be submitted on NAIC annual statement blanks, including fully completed and executed jurat pages subscribed and sworn to by the applicant's president, secretary and treasurer.

ii. The statement submitted for the most recent year shall be for a calendar year ending not more than nine months prior to the date of submission of the application; and

3. The applicant's quarterly financial statements for the current year in the NAIC format.

(c) Alien applicants shall submit the following to the Commissioner in addition to the requirements in (a) above:

1. Two duly authenticated copies of its current annual financial statement; one in the language and monetary value of its country of domicile and one in the English language with all monetary values expressed in United States dollars at the current exchange rate shown in the statement;

i. The statement shall be for a calendar year ending not more than nine months prior to the date the filing of such statement in the applicant's country of domicile is due.

2. If the applicant is registered with the NAIC Non-Admitted Insurers Information Office, a copy of the Standard Financial Reporting Format submitted to the NAIC Non-Admitted Insurers Information Office;

3. A description of the deposits and amounts thereof for the benefit of all United States policyholders for all United States jurisdictions in which the applicant is currently transacting business; and

4. A copy of a duly executed trust fund agreement for the benefit of the applicant's United States policyholders in the amount of not less than $2,500,000 as required by N.J.A.C. 11:1-31.3(d)1.

(d) The Commissioner shall notify the applicant within 60 days whether the application is complete. If the application is incomplete, the notice shall specify the items or information necessary to cure the deficiency.

11:1-31.5 Certificate of eligibility; issuance

(a) If the applicant demonstrates that it fulfills the requirements for eligibility in N.J.S.A. 17:22-6.45 and this subchapter, the Commissioner shall issue a Certificate of Eligibility to the applicant.

(b) The Certificate of Eligibility shall remain continuously in effect unless the Commissioner withdraws eligibility as set forth in N.J.A.C. 11:1-31.6.

11:1-31.6 Withdrawal of eligibility

(a) The Commissioner may withdraw the eligibility of an insurer to insure surplus lines risks in this State if:

1. The insurer fails to file the data required or otherwise comply with the requirements for continued surplus lines eligibility as certified by the insurer in its application for eligibility pursuant to N.J.A.C. 11:1-31.4(a)15;

2. The Commissioner has reason to believe that the eligible surplus lines insurer is insolvent, in an unsound financial condition or no longer in compliance with N.J.S.A. 17:22-6.40 et seq. or this subchapter; or

3. The Commissioner finds, after a hearing thereon in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1, of which notice was given to all licensed surplus lines agents, that an eligible surplus lines insurer has willfully violated the laws of this State or does not make reasonably prompt payment of just losses and claims in this State.

(b) The Commissioner shall notify all licensed surplus lines agents in this State of withdrawals of eligibility made pursuant to this section.

(c) Except as otherwise specified by the Commissioner, an insurer whose eligibility has been withdrawn pursuant to (a) above shall be prohibited from writing any new business or renewing existing business, but shall continue to service existing business through expiration of each policy.

11:1-31.7 Failure to comply with subchapter; denial of certificate of eligibility

Failure to submit the information required by this subchapter completely and accurately may result in the denial of a certificate of eligibility to transact business as an eligible surplus lines insurer in this State.

INSURANCE

(a)

DIVISION OF ACTUARIAL SERVICES

Minimum Standards for Medicare Supplement Coverage

Proposed New Rules: N.J.A.C. 11:4-23.7, 23.8, 23.9, 23.20 and 23.21 and Exhibits D, E, F, and G to the Appendix to Subchapters 16 and 23.

Proposed Amendments: N.J.A.C. 11:4-16.8, 23.2, 23.3, 23.4, 23.5, 23.6, 23.10, 23.11, 23.12, 23.13, 23.14, 23.15, 23.16, 23.17, and Exhibits A, B and C to the Appendix to Subchapters 16 and 23.

Proposed Repeal: N.J.A.C. 11:4-25 and Appendix A

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:22A-1 et seq., 17:35C-1 et seq., 17B:26A-1 et seq., and 17B:30-1 et seq.

Proposal Number: PRN 1992-17.

Submit comments by February 5, 1992 to:

Verice M. Mason, Assistant Commissioner
Division of Legislative and Regulatory Affairs
New Jersey Department of Insurance
20 West State Street
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Trenton, New Jersey 08625

The agency proposal follows:

Summary

On November 5, 1990, the Federal Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, ("OBRA 90"), was enacted, significantly amending Section 1882 of Title XVIII of the Social Security Act. Among other changes, OBRA 90 eliminated the voluntary nature of the Federal certification of State Medicare supplement regulatory programs. That is, in states which fail to maintain a certified Medicare supplement regulatory program, as determined by the Secretary of the United States Department of Health and Human Services ("Secretary"), a dual regulatory system will be effected. No Medicare supplement policies or certificates may be delivered or issued for delivery in such a state unless and until the policy is submitted to and approved by the Secretary as a Medicare supplement policy, and by the Commissioner of Insurance of the non-certified state as a policy meeting the laws of that state. In order to maintain certification and avoid the dual regulatory system, states must amend their laws commensurate with the OBRA 90 changes in Federal standards.

OBRA 90 authorized changes to be implemented through models developed by the National Association of Insurance Commissioners ("NAIC"), if such models could be developed within nine months of the date of enactment of OBRA 90. On July 30, 1991, the NAIC adopted models implementing OBRA 90, meeting the statutory deadline. In accordance with OBRA 90, states have one year from the date of adoption of the NAIC model (that is, July 30, 1992) within which to come into compliance with the Federal standards.

The proposed new rules and rule amendments contained herein are intended to bring New Jersey's rules substantially into compliance with the NAIC's "Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." To the extent that New Jersey's rules already comply with or are more stringent than the NAIC's July 30, 1991 model, current New Jersey rules have been retained. States are permitted to be more stringent than the NAIC model.

Some of the proposed changes are as follows: (1) Medicare supplement policy designs have been standardized and limited to 10 plans; (b) rebates or credits of premium must be provided when loss ratio standards have not been met; (c) carriers must provide that persons 65 years or older may enroll in or purchase a Medicare supplement policy within six months following their 65th birthday without being subjected to medical underwriting (open enrollment); (d) carriers must provide for suspension of benefits and premium payments, subject to reinstatement, of Medicare supplement policies or certificates held by individuals who become entitled to Medicaid, upon the request of the individual; and (e) agent responsibilities and marketing practices are more clearly delineated.

N.J.A.C. 11:4-16.8 is proposed for amendment at subsections (b) and (1) based on citation revisions due to proposed amendments and new rules in N.J.A.C. 11:4-23.

N.J.A.C. 11:4-23.1 is proposed for amendment to clarify that the purpose of the subchapter is no longer limited to providing standards for Medicare supplement policies sold to persons eligible for Medicare by reason of age, but to all Medicare supplement policies.

N.J.A.C. 11:4-23.2 is proposed for amendment to include within the scope of the subchapter certificates delivered or issued for delivery in New Jersey.

N.J.A.C. 11:4-23.3, which sets forth definitions for the subchapter, is proposed for amendment by inclusion of a definition of the terms "aggregate loss ratio," "anticipated loss ratio," and "carrier," and deletion of the term "insurer." This proposed amendment is intended to clarify the general applicability of the subchapter to various industry entities.

N.J.A.C. 11:4-23.4, which sets forth definitions for policy terms, is proposed for amendment primarily to include a definition of the term "health care expenses" relevant for health maintenance organizations.

N.J.A.C. 11:4-23.5 is proposed for amendment to clarify that Medicare supplement policies and certificates cannot include limitations or exclusions which are more restrictive than the limitations and exclusions of Medicare. As such, the list of possible limitations and exclusions under current N.J.A.C. 11:4-23.5(a) is unnecessary, and is deleted.

N.J.A.C. 11:4-23.6 is proposed for amendment to set forth the general minimum benefit standards applicable to policies and certificates issued on or after the effective date of adoption of these proposed new rules and rule amendments, as well as those policies issued prior to the effective date. The NAIC has included standards for both pre- and post-OBRA 90 policies in its model. To the extent that the standards are the same for all such policies, the standards are reflected at N.J.A.C. 11:4-23.6 with proposed amendments.

N.J.A.C. 11:4-23.7 is proposed for recodification as N.J.A.C. 11:4-23.10 with amendments. The proposed recodified and amended rule sets forth the explicit standards for claims payments to be met by carriers with regard to Medicare supplement policies.

N.J.A.C. 11:4-23.8 is proposed for recodification as N.J.A.C. 11:4-23.11 with amendments. The proposed recodified and amended rule contains loss ratio standards, rate filing requirements and the proposed standards for determining refunds and credits.

N.J.A.C. 11:4-23.9 is proposed for recodification as N.J.A.C. 11:4-23.12 with amendments. The proposed recodified and amended rule contains form filing requirements, limiting the number of different forms for each Medicare supplement plan that a carrier may file.

N.J.A.C. 11:4-23.10 is proposed for recodification as N.J.A.C. 11:4-23.13 with amendments. The proposed recodified and amended rule contains standards for producer compensation, further restricting the compensation arrangement variables.

N.J.A.C. 11:4-23.11 is proposed for recodification as N.J.A.C. 11:4-23.14 with amendments. The proposed recodified and amended rule sets forth required disclosure provisions, including new disclosures regarding premiums. As proposed, the Outline of Coverage included in this rule is deleted in favor of new individualized Medicare supplement plan charts, proposed within the Appendix to Subchapters 16 and 23 of Chapter 4, at Exhibit D.

N.J.A.C. 11:4-23.12 is proposed for recodification as N.J.A.C. 11:4-23.15 with amendments. The proposed recodified and amended rule sets forth the requirements for application forms and replacements of coverage. As proposed, application forms must contain specific questions designed to determine whether the new coverage will duplicate other coverage, and whether the new coverage is of any value to the applicant. As proposed, the "Notice to Applicant Regarding Replacement and Sickness or Medicare Supplement Coverage" is being deleted in favor of a similar, updated notice contained in Exhibit E of the Appendix to Subchapters 16 and 23 of Chapter 4.

N.J.A.C. 11:4-23.14 is proposed for recodification as N.J.A.C. 11:4-23.17 with amendments. The proposed recodified and amended rule sets forth the standards for marketing of Medicare supplement policies.

N.J.A.C. 11:4-23.15 is proposed for recodification as N.J.A.C. 11:4-23.18 with amendments. The proposed recodified and amended rule sets forth the standards for determining the appropriateness of a sale of Medicare supplement policies. The current rule would allow sales of Medicare supplement policies to persons with other forms of coverage if, in combination, the person would have coverage for no more than 100 percent of actual medical expenses allowable under the combined policy. As proposed, this allowable contingency is deleted.

N.J.A.C. 11:4-23.16 is proposed for recodification as N.J.A.C. 11:4-23.19 with amendments. The proposed recodified and amended rule requires reporting by carriers of known sales of more than one of their Medicare supplement policies to a single individual. A form for reporting this information is contained in proposed Exhibit G of the Appendix to Subchapters 16 and 23 of Chapter 4.

N.J.A.C. 11:4-23.17 is proposed for recodification as N.J.A.C. 11:4-23.22 without additional amendment.

Proposed new rule N.J.A.C. 11:4-23.7 sets forth the minimum benefit standards specific to policies delivered or issued for delivery prior to the effective date of the adoption of these proposed new rules and rule amendments contained herein (that is, policies issued prior to this State's compliance with OBRA 90, but subsequent to this State's compliance with the Medicare Catastrophic Coverage Repeal Act of 1989, P.L.101-234, or "MCCRA").

Proposed new rule N.J.A.C. 11:4-23.8 sets forth the minimum benefit standards applicable to policies and certificates delivered or issued for delivery on or after the effective date of these proposed new rules and rule amendments. Proposed new rule N.J.A.C. 11:4-23.8 contains the requirement that Medicare supplement policies be suspended during periods of Medicaid entitlements. It also sets forth the 10 Medicare supplement plan designs, and specifications of each benefit.

Proposed new rule N.J.A.C. 11:4-23.9 sets forth the open enrollment requirement for Medicare supplement policies.

Proposed new rule N.J.A.C. 11:4-23.20 provides routing information for the various filings carriers must make with the Department of Insurance in compliance with N.J.A.C. 11:4-23.

Proposed new rule N.J.A.C. 11:4-23.21 is a penalty provision for failure to comply with the subchapter.

As proposed, the Appendix to Subchapters 16 and 23 of Chapter 4 is amended and expanded significantly. Exhibit A, containing the booklet **Bridging the Medicare Gaps: A Guide to Medicare Supplements**, is amended primarily to reflect the changes brought to bear by OBRA 90. Exhibit B, containing a chart to be inserted in the back pocket of **Bridging the Medicare Gaps: A Guide to Medicare Supplements**, entitled "Medicare Deductibles and Co-payments for 19__," is amended to reflect the anticipated deductibles and co-payments for Medicare in 1992. Exhibit C, containing a chart entitled "Notice of Changes in Medicare and Your Medicare Supplement Coverage—1991," is amended to make the chart somewhat more generic for use in subsequent years.

Proposed new Exhibit D contains the Outlines of Coverage for the proposed 10 Medicare supplement plan designs. Exhibit D consists of three parts: (1) the Cover Page(s); (2) the Disclosure Page(s); and (3) the separate Plan Charts.

Proposed new Exhibit E contains the notice to be provided to applicants who are intending to replace one Medicare supplement policy with another such policy.

Proposed new Exhibit F contains the forms and valuation tables to be used by carriers in determining refund or credit calculations with respect to Medicare supplement premium.

Proposed new Exhibit G contains the form carriers may use for their annual report of multiple sales of Medicare supplement policies to individuals resident in New Jersey.

N.J.A.C. 11:4-25, entitled Medicare Supplement Minimum Standards Transition Rule for 1990, and Appendix A to subchapter 25 are proposed for deletion in their entirety, because both the subchapter and Appendix A, which were promulgated in compliance with the MCCRA, are no longer necessary.

Social Impact

The Federal government continues to make revisions in the area of Medicare and Medicare supplement standards in response to perceived abusive industry practices and consumer confusion. Federal penalties for certain industry practices considered abusive have been instituted or greatly enhanced by OBRA 90. Combined with standardization of Medicare supplement plan designs, consumers should benefit significantly from OBRA 90, and this State's compliance with the Federal law.

Standardization of plans will make comparison of different companies' policies simpler and clearer for consumers. In addition, standardization assures that the benefits provided are meaningful, and do not duplicate benefits in any facet under Medicare. Open enrollment also benefits consumers significantly by assuring that those 65 and older who want to purchase Medicare supplement coverage will have an opportunity to do so.

Suspension of Medicare supplement policies (subject to reinstatement) when an individual becomes entitled to Medicaid allows those least able to afford coverage a significant opportunity to maximize their coverage dollars, and be assured of continuity in coverage. Additionally, it is of great importance to those persons under age 65 who qualify for Medicare that they may now purchase Medicare supplement policies meeting all the standards and protections previously afforded exclusively to those persons aged 65 and older. This should help ease some of the gaps in coverage for this segment of the Medicare population which heretofore existed.

Of particular importance to this State is that, as New Jersey continues to become more "mainstream" with respect to Federal law and the actions of the other states, the Medicare Supplement marketplace should expand, offering consumers more choice and competitive pricing.

Economic Impact

Consumers should find it easier to understand the variation in plan premiums, given the standardization of Medicare supplement plans. This, combined with the required disclosure by carriers of certain of their pricing practices, should better enable consumers to determine a specific policy's affordability, and whether it is a wise purchase based on individual needs and financial capabilities.

Carriers will incur additional costs in recordkeeping, reporting and form filing. However, the economic incentive is significant, and broad enough to encourage healthy competition in the marketplace. The positive economic impact should balance any negative economic impact for carriers over time.

The Department of Insurance (Department) anticipates using significant resources in filing and reviewing the new forms, rates, refund calculations and multiple policy reports as well as advertising materials. In addition, the Department anticipates expending additional resources in complying with the periodic review process of State programs required by the Secretary under OBRA 90. The Department will function to the best of its abilities within current resource levels, but it is not clear that current staffing levels and space will continue to be adequate to assure optimal efficiency with respect to these policies.

Regulatory Flexibility Analysis

These proposed new rules and rule amendments do impose additional recordkeeping, reporting and compliance requirements, as described in the Summary above. However, these requirements are required through Federal law and Federal standards which these proposed new rules and rule amendments substantially parrot. While the State may be more stringent, it may not be less stringent than the Federal standards if it is to maintain a certified Medicare supplement regulatory program. Thus, it is the Department's position that it is not at liberty to decrease any of the recordkeeping, reporting or compliance requirements.

The Department does not believe that any of the carriers required to comply with these proposed new rules and rule amendments are "small businesses" as that term is defined at N.J.S.A. 52:14B-16 et seq. Some of the agency business probably does qualify as statutory small businesses. Inasmuch as the Federal law provides no distinctions between sizes of involved businesses, however, the Department is not inclined to relax the proposed new rules or rule amendments for small businesses.

Full text of the proposed repeals can be found in the New Jersey Administrative Code at N.J.A.C. 11:4-25 and 11:4-25 Appendix A.

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

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

11:4-16.8 Required disclosure provisions

(a) (No change.)

(b) Outline of coverage-general rules include:

1. No individual health insurance policy shall be delivered or issued for delivery in this State unless the appropriate outline of coverage in (c) through (n) below is completed as to such policy and:

i. For policies offered for sale as Medicare supplement policies, the outline meets the requirements set forth at N.J.A.C. 11:4-[23.11] **23.14**; and

ii. (No change.)

2.-8. (No change.)

9. For the outline of coverage prescribed by N.J.A.C. 11:4-16.8(i), (k)[, (1)] and (n), the following instructions apply:

i.-iii. (No change.)

(c)-(k) (No change.)

(l) An outline of coverage regarding Medicare supplement coverage[,] shall be issued in connection with policies in compliance with N.J.A.C. 11:4-16.6(j). The outline of coverage shall meet the requirements of N.J.A.C. 11:4-[23.11]**23.14**.

SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE

11:4-23.1 Purpose

This subchapter provides for the reasonable standardization of coverage and the simplification of terms and benefits of Medicare supplement policies; facilities comparison of such policies in order to increase public understanding; eliminates provisions which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims and provides for full disclosure in the sale of health care service benefits and insurance to persons eligible for Medicare [by reason of age].

11:4-23.2 Applicability and scope

(a) [Except as otherwise specifically provided in N.J.A.C. 11:4-23.8 and 23.9, this] **This** subchapter shall apply to:

1. All medicare supplement policies, as defined by this subchapter, delivered or issued for delivery in this State [on or after July 1, 1991];

2. All certificates, as defined by this subchapter, issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State [on or after July 1, 1991].

(b) This subchapter shall apply to all carriers, as defined in this subchapter, delivering or issuing for delivery Medicare supplement policies in this State, or delivering or issuing for delivery certificates in this State, which certificates were issued under a group Medicare supplement policy.

11:4-23.3 Definitions

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

"Aggregate loss ratio" means the ratio of the accumulated value of past benefits (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future benefits to the accumulated value of past premiums (from the original effective date of the form to the date as of which the ratio is determined) and the present value of future premiums. Benefits shall not be increased nor premiums reduced by actual or anticipated dividends, and interest shall be included in the accumulated and present values on the same basis as in the present values of the anticipated loss ratio.

"Anticipated loss ratio" means the ratio of the present value of the expected benefits, not including dividends, to the present value of the expected premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. For purposes of this ratio, the present values must incorporate realistic rates of interest which are determined before Federal taxes but after investment expenses. Benefits and premiums shall be discounted from the year of payment, with reasonable assumptions as to time of payment within the year.

"Applicant" means:

1. In the case of a group policy, the proposed certificate holder;

2. In the case of an individual policy, the person who seeks to contract for coverage.

"Carrier" means any person who contracts to provide health services, reimburse the cost of health services in whole or in part, or provide an indemnity in the event that health services are used, in return for a prepaid or postpaid premium or other consideration, including insurance companies, fraternal benefit societies, hospital, medical and health service corporations, health maintenance organizations and such other similar entities.

"Certificate" means any certificate or other document which sets forth or summarizes the essential features of the coverage issued under a group policy, which certificate or other document has been delivered or issued for delivery in this State.

"Coverage" means:

1. Any arrangement whereby [an insurer] **a carrier** agrees to indemnity or reimburse an individual or group member for some portion or part of the health related costs incurred by that individual or member, subject to the terms of the written agreement and law; and

2. Any arrangement whereby [an insurer] **a carrier** agrees to provide direct or indirect health care services to the individual or group member, subject to the terms of the written agreement and law.

"Insured" means any applicant provided coverage by [an insurer] **a carrier.**

["Insurer" means any person who contracts to provide health services, reimburse the cost of health service in whole or in part, or provide an indemnity in the event that health services are used, in return for a prepaid or postpaid premium or other consideration.]

"Medicare supplement policy" means a group or individual policy which is advertised, marketed or designed primarily as, or is otherwise held out to be, a supplement to reimbursements under Medicare [by reason of age]. This term does not include a policy **or certificate** of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization.

"Policy" shall mean any policy, contract, certificate or other document which sets forth or summarizes the essential features of the coverage issued to an individual or group by [an insurer] **a carrier**, for the purpose of providing Medicare supplement coverage, including any such policy issued pursuant to a conversion privilege to an individual 65 years of age or older, except as otherwise provided in this subchapter or Federal law.

11:4-23.4 Policy definitions and terms

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

1.-2. (No change.)

3. "Convalescent nursing home,"[,] "extended care facility,"[,] or "skilled nursing facility" shall **not** be defined **more restrictively than as defined by the Medicare program** [in relation to its status, facilities and available services.

i. A definition of such home or facility shall not be more restrictive than one requiring that it:

1. Be operating pursuant to law;

2. Be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

3. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

4. Provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

5. Maintain a daily medical record of each patient.

ii. The definition of such home or facility may provide that such term shall not be inclusive of:

1. Any home facility, or part thereof used primarily for rest;

2. A home or facility for the aged or for the care of drug addicts or alcoholics; or

3. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care].

4. "Health care expenses" means expenses of health maintenance organizations which expenses are associated with the delivery of health care services and are analogous to incurred losses of insurers. Such expenses shall not include the following costs unless these costs would be considered consistent with the requirements set forth by Federal regulation at Title 42 of the Code of Federal Regulation, section 417.243(f)(2), or unless these costs would be allowable under Title 42 of the Code of Federal Regulation, section 417.243(f)(1) or any successor provisions related to allowable expenses:

i. Home office and overhead costs;

ii. Advertising costs;

iii. Commissions and other acquisition costs;

iv. Taxes;

v. Capital costs;

vi. Administrative costs; and

vii. Claims processing costs.

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

[i. The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

1. Be an institution operated pursuant to law;

2. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

3. Provide 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

ii. The definition of the term "hospital" may state that such term shall not be inclusive of:

1. Convalescent homes, convalescent, rest, or nursing facilities;

2. Facilities primarily affording custodial, educational, or rehabilitory care;

3. Facilities for the aged, drug addicts, or alcoholics; or

4. Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.]

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

[6.]**7.** "Medicare eligible expense" shall mean [health care] expenses of the kinds covered by Medicare, to the extent recognized as reasonable **and medically necessary** by Medicare. [Payments of benefits by insurers for Medicare eligible expenses shall be conditioned upon the same or less restrictive payment conditions as are applicable to Medicare claims, including the determinations of medical necessity.

7. "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder or any kind.

8. "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the Board of Nursing or any other registry board of the State.]

[9.]**8.** "Physician" [may] **shall not** be defined **more restrictively than as defined by the Medicare program** [by including words such as "duly qualified physician" as "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the policy or contract, all providers of medical care and treatment when such services are within the scope of the providers' licensed authority and are provided pursuant to applicable laws.].

Recodify existing 10.-12. as **9.-11.** (No change in text.)

11:4-23.5 [Prohibited] **Policy** provisions

(a) No policy **or certificate** shall be advertised, solicited, **delivered** or issued for delivery in this State as a Medicare supplement policy **if such policy or certificate contains limitations or exclusions that are more restrictive than those of Medicare, except with respect to preexisting condition limitations.** [it limits or excludes coverage by type of illness, accident, treatment, or medical condition, except as follows:

1. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Illness, treatment, or medical condition arising out of:

i. War or act of war (whether declared or undeclared), participation in a riot or insurrection, service in the armed forces or units auxiliary thereto;

ii. Suicide (while sane or insane), attempted suicide, or intentionally self-inflicted injury;

iii. Aviation, other than as a fare-paying passenger on a regularly scheduled airline;

4. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

5. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation in the vertebral column;

6. Treatment provided in a governmental hospital, benefits provided under Medicare or other governmental program (except Medicaid), and State or Federal worker's compensation, employer's liability or occupational disease law, or any mandatory motor vehicle no-fault law, services rendered by employees of hospitals, laboratories, or other institutions, services performed by a member of the covered person's immediate family, and services for which no charge is normally made in the absence of insurance or service benefits;

7. Dental care or treatment;

8. Eyeglasses, hearing aids, and examination for the prescription or fitting thereof;

9. Rest cures, custodial care, transportation, and routine physical examinations;

10. Territorial limitations outside the United States.

(b) Medicare supplement policies shall not contain limitations or exclusions of the type enumerated in (a) 1, 5, 9 or 10 above that are more restrictive than those of Medicare.]

[(c)]**(b)** No Medicare supplement policy **or certificate** shall provide benefits which duplicate [the] benefits [available to a covered person under Part A or Part B of] **provided by** Medicare.

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

[(e) The terms "Medicare supplement," "Medigap" and words of similar import shall not be used unless the policy or contract is used in compliance with N.J.A.C. 11:4-23.6 and all other sections of this subchapter.]

11:4-23.6 [Minimum] **General minimum** benefit standards

(a) No policy **or certificate** shall be advertised, solicited or issued for delivery in this State as a Medicare [Supplement] **supplement** policy if it does not meet the minimum standards contained in this section. [These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.]

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

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

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

3. A Medicare supplement policy **or certificate** shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amounts and copayment percentage factors and out of pocket maximums, **if any,** in response to which premiums may be correspondingly modified subject to the requirements of N.J.A.C. 11:4-[23.8]**23.11**.

4. A Medicare supplement policy **or certificate** shall not:

i. (No change.)

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

5. Termination of a Medicare [Supplement] **supplement** policy **or certificate** shall be without prejudice to any continuous loss which commenced while the policy **or certificate** was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the covered person limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

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

(c) Except as may be authorized by the Commissioner, [an insurer] **a carrier** shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation. **With respect to terminations of group policies, or membership in a group, the following standards shall apply:**

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

i. (No change.)

ii. An individual Medicare supplement policy which provides only such benefits as **otherwise** are required to meet [this State's minimum standards] **N.J.A.C. 11:4-23.8**.

2. If membership in a group is terminated, the [insurer] **carrier** shall:

i.-ii. (No change.)

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

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

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

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

3. For Medicare supplement policies subject to the minimum standards adopted by this State pursuant to the Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be as set forth at (e) below.

(e) The minimum benefit standards for Medicare supplement policies are:

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

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

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

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

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

11:4-23.7 Minimum benefits for policies delivered or issued for delivery prior to the effective date of this subchapter

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

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

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

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

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

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

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

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

iv. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

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

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

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

(c) Medicare supplement policies shall be guaranteed renewable.

11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after the effective date of this subchapter

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

(b) Medicare supplement policies shall be guaranteed renewable.

(c) A Medicare supplement policy or certificate shall provide that benefits and premiums shall be suspended for a period of up to 24 months upon the request of a policyholder or certificateholder who has applied for and been determined entitled to medical assistance under Title XIX of the Social Security Act (that is, Medicaid), during or at the end of which period of suspension, the policy or certificate shall be reinstituted automatically upon notice to the carrier by the policyholder or certificateholder.

1. Benefits and premiums shall not be suspended unless the policyholder or certificateholder provides the carrier notice of entitlement to medical assistance under Title XIX of the Social Security Act within 90 days following the date the policyholder or certificateholder was determined to be so entitled.

2. Upon receipt of a notice of entitlement to medical assistance, the carrier shall return to the policyholder that portion of the premiums already paid which are attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

3. Upon loss of entitlement to medical assistance within the period of suspension, or upon the date following the final day of the period of suspension, the policy or certificate shall be automatically reinstituted, effective as of the date of termination of entitlement, or effective as of the day following the final day of the period of suspension, if within 90 days following the date of entitlement termination or the final day of the suspension period, the policyholder or certificateholder provides notice to the carrier for reinstitution of the policy or certificate, and pays the premium required by the carrier, which premium shall be for a period of coverage not exceeding six months, inclusive of the 90 day notice period, but exclusive of any period during which the policyholder or certificateholder was entitled to medical assistance pursuant to Medicaid.

4. The coverage under the policy or certificate reinstated:

i. Shall not be subject to any waiting period with respect to treatment of preexisting conditions;

ii. Shall be substantially equivalent to coverage which was in effect prior to the date of suspension of the policy or certificate; and

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

(d) All carriers delivering or issuing for delivery in this State Medicare supplement policies or certificates of group Medicare supplement policies shall offer to all applicants a policy or certificate providing no more than the core benefits defined at (g) below. A policy or certificate providing only core benefits shall be designated as standardized Medicare supplement benefit plan A.

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

1. Standardized Medicare supplement benefit plan B shall provide:

i. The Core Benefit; and

ii. The Medicare Part A Deductible benefit.

2. Standardized Medicare supplement benefit plan C shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medicare Part B Deductible benefit; and

v. The Medically Necessary Emergency Care in a Foreign Country benefit.

3. Standardized Medicare supplement benefit plan D shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and

v. The At-Home Recovery Benefit.

4. Standardized Medicare supplement benefit Plan E shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medically Necessary Emergency Care in a Foreign Country benefit; and

v. The Preventive Medical Care benefit.

5. Standardized Medicare supplement benefit plan F shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medicare Part B Deductible benefit;

v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit; and

vi. The Medically Necessary Emergency Care in a Foreign Country benefit.

6. Standardized Medicare supplement benefit plan G shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Eighty Percent (80%) of the Medicare Part B Excess Charges benefit;

v. The Medically Necessary Emergency Care in a Foreign Country benefit; and

vi. The At-Home Recovery Benefit.

7. Standardized Medicare supplement benefit plan H shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Basic Outpatient Prescription Drug Benefit; and

v. The Medically Necessary Emergency Care in a Foreign Country benefit.

8. Standardized Medicare supplement benefit plan I shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;

v. The Basic Outpatient Prescription Drug Benefit; and

vi. The Medically Necessary Emergency Care in a Foreign Country benefit; and

vii. The At-Home Recovery Benefit.

9. Standardized Medicare supplement benefit plan J shall provide:

i. The Core Benefit;

ii. The Medicare Part A Deductible benefit;

iii. The Skilled Nursing Facility Care benefit;

iv. The Medicare Part B Deductible benefit;

v. The One-Hundred Percent (100%) of the Medicare Part B Excess Charges Benefit;

vi. The Extended Outpatient Prescription Drug Benefit;

vii. The Medically Necessary Emergency Care in a Foreign Country benefit;

viii. The Preventive Medical Care benefit; and

ix. The At-Home Recovery Benefit.

(f) No groupings, packages or combinations of Medicare supplement benefits shall be offered which differ from the standardized Medicare supplement benefit plans specified in (d) and (e) above, except as an Innovative Benefit which may be approved by the Commissioner. Benefit plans shall be uniform in structure, language, designation and format to the standardized Medicare supplement benefit plans A, B, C, D, E, F, G, H, I and J as set forth in (d) and (e) above. For purposes of this section, "structure," "language," and "format" means style, arrangement and overall content of a benefit.

(g) The following terms and phrases, as used in this section, shall have the following meanings:

1. "At-Home Recovery Benefit" means coverage for services to provide short term, at-home assistance with activities of daily living for persons recovering from an illness, injury or surgery. At-home recovery services shall be services which are designed primarily to assist with activities of daily living.

i. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services prescribed are necessary due to a condition for which a home care plan of treatment was approved by Medicare.

ii. Coverage shall be limited to:

(1) The number and type of at-home recovery visits certified as necessary by the insured's attending physician, received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit, the total number of which shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(2) Care furnished on a visiting basis in the insured's home by a care provider as defined at (g)1v below for up to seven visits in any one week; and

(3) Actual charges up to $40.00 per visit to a maximum per calendar year benefit of $1,600.

iii. Coverage shall be excluded for home care visits reimbursed by Medicare or other government programs and for care provided by family members, unpaid volunteers, or providers who do not otherwise meet the definition of a care provider, to the extent Medicare would exclude coverage for care provided by such individuals.

iv. Activities of daily living shall include, but not be limited to, bathing, dressing, personal hygiene, eating, ambulating, assistance with drugs that are normally self-administered, and changing of bandages or other dressings.

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

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

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

2. "Basic Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a $250.00 calendar year deductible and a maximum per calendar year benefit per insured of $1,250.

3. "Core Benefit" means coverage of:

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

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

iii. Medicare Part A eligible expenses for hospitalization upon exhaustion of Medicare hospital inpatient coverage, including lifetime reserve days, up to a maximum lifetime benefit of 365 days, to be paid at the Diagnostic Related Group (DRG) outlier day per diem, or 90 percent of eligible expenses if a DRG is not applicable;

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

v. The coinsurance amount of Medicare Part B eligible expenses, regardless of hospital confinement, subject to the Medicare Part B deductible.

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

5. "Extended Outpatient Prescription Drug Benefit" means coverage for 50 percent of outpatient prescription drug charges to the extent not covered by Medicare, subject to a $250.00 deductible per calendar year, and a maximum per calendar year per insured benefit of $3,000.

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

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

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

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

10. "One Hundred Percent (100%) of the Medicare Part B Excess Charges" means coverage for all of the difference between the Medicare Part B approved charge and the actual Medicare Part B billed charge, up to but not exceeding any charge limitation established by the Medicare program or this State's law, if any.

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

i. An annual clinical preventive medical history and physical examination that shall include patient education to address preventive health care measures and any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(1) Fecal occult blood test and/or digital rectal examination;

(2) Mammogram;

(3) Dipstick urinalysis for hematuria, bacteriuria, and proteninauria;

(4) Pure tone (air only) hearing screening test administered or ordered by a physician;

(5) Serum cholesterol screening (every five years);

(6) Thyroid function test; and

(7) Diabetes screening;

ii. Influenza vaccine administered at any appropriate time during a calendar year;

iii. Tetanus and diphtheria booster (every 10 years); and

iv. Other tests or preventive measures determined appropriate by the attending physician.

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

11:4-23.9 Open Enrollment

(a) Applicants qualified for Medicare shall not be denied coverage under a Medicare supplement policy or certificate because of the applicant's age.

(b) With respect to applicant's aged 65 years or older, carriers shall not deny or condition the effectiveness or issuance, nor discriminate in the pricing of Medicare supplement policies or certificates based on the health status, claims experience, receipt of health care by, or medical condition of an applicant if the applicant applies for Medicare supplement coverage within the six month period following the applicant's enrollment date under Medicare Part B.

(c) Neither (a) nor (b) above shall be construed to prohibit or limit a carrier's use of permissible preexisting condition exclusion provisions in any Medicare supplement policy or certificate.

11:4-[23.7]**23.10** Standards for claims payment

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

1. Acceptance of notice from a Medicare-Carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits under the Medicare supplement policy or certificate as sufficient claim notice without requiring other or additional claims forms to be submitted, and making a payment determination based on the information contained in the notice from the Medicare-Carrier;

2. Notification of the participating physician or supplier, and the beneficiary, of the payment determination, and making payment directly to the participating physician or supplier;

3. Providing each enrollee, at the time of enrollment, a card listing the policy name, policy number, and a mailing address to which notices from a Medicare-Carrier may be sent;

4. Payment of user fees for claim notices that are transmitted electronically or otherwise; and

5. Providing to the Secretary of Health and Human Services at least annually, a central mailing address to which all claims may be sent by the Medicare-Carrier.

(b) Compliance with the requirements set forth in (a) above [must] **shall** be certified on the Medicare supplement experience reporting form.

(c) (No change.)

11:4-[23.8]**23.11** Loss ratio standards, **annual filing of premium rates and refund or credit calculation**

(a) Medicare supplement [policies] **policy forms or certificate forms** shall be expected to return to policyholders **and certificateholders** in the form of aggregate benefits under the policy **or certificate (exclusive of any anticipated refund or credit)**, for the entire period for which rates are computed to provide coverage, **calculated on the basis of paid claims experience (or paid health care expenses for coverage provided by a health maintenance organization on a service rather than reimbursement basis) and written premiums for such period and with adjustment for interest to reflect the timing of payments:**

1.-2. (No change.)

(b) Each carrier shall include with the initial submission of rates for a new Medicare supplement policy an actuarial memorandum which includes the following:

1. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery for each form in each such year;

2. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, where any statutorily required additional actuarial active life reserve is neither reflected in the future benefits nor the future premiums in the calculation;

3. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, where neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserve;

4. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein:

i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserve for each such year; and

ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

5. The realistic assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

i. The annual claim costs (ultimate) by attained age and sex;

ii. The select and/or antiselect morbidity factors by policy duration (year) by issue age and sex;

iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from model premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent, current and future expected new investment return rates (after investment expenses, but before Federal income taxes);

vi. Expenses by policy duration, including commission, override and bonus rates, other marketing expense rates, other maintenance expenses rates, any new-market expense rates, other acquisition expense rates, and the explicit profit margin or risk charge, provided on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, and any other applicable bases;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex;

viii. The percentage of policies expected to be issued with extra premiums for any physical, mental or medical conditions which result in substandard morbidity; and

ix. A summary statement of the underwriting standards (for example: short form medical and risk questionnaire, long form medical and risk questionnaire, medical examination), the marketing distribution system, and the market for the policy form (that is, the segment(s) of the general public to which the form will be marketed: middle income based on predetermined ZIP code selections for example);

6. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

7. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the recognition or nonrecognition or the homogenization of the elements of any insurance construct will not result in an anticipated loss ratio which would differ by more than 10 percent from the anticipated loss ratio of any element of the construct if the elements of the construct were not recognized or separately recognized, as the case may be.

ii. For the purpose of this paragraph, construct shall mean the risk variables which significantly affect the cost of the coverage. For example, age could be a construct wherein its elements would be age 65, age 66, age 67 and so forth. (Of particular concern are anticipated loss ratios by issue age or issue age groupings.); and

8. A certification signed by an actuary who must be a member of the Society of Actuaries or Casualty Actuarial Society, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio.

[(b)](c) Every [insurer] **carrier** shall submit annually for filing by the Commissioner its rates[, rating schedule and all supporting]. **Supporting** documentation [which the Commissioner may require], including ratios of incurred losses to earned premiums by [number of years of] policy duration **shall be submitted annually with the rates. Any revision of rates is subject to the requirements of (d) below.** [to demonstrate that the insurer is in compliance with the applicable loss ratio standard of (a) above and that the period for which the policy is rated is reasonable. Every insurer shall provide annually the following information:

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three years or more; and

2. The expected losses in relation to premiums over the entire period for which the policy is rated, subject to a demonstration of an expected third-year loss ratio which is greater than or equal to the applicable percentage of (a) above for policies or certificates in force less than three years.] **The supporting documentation shall demonstrate, using reasonable assumptions, that the anticipated and aggregate loss ratio are at least as great as the originally anticipated loss ratio. Such demonstration shall exclude active life reserves.**

(d) Carriers shall submit for filing by the Commissioner in accordance with N.J.A.C. 11:4-23.12 all rate revisions. No carrier shall implement any rate revision until such rate revision has been filed. Submission of rate revisions for filing shall demonstrate that both the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage and the aggregate loss ratio are at least as great as the originally anticipated loss ratio.

1. Prior to the effective date of enhancements in Medicare benefits, carriers shall:

i. Submit for filing appropriate premium adjustments required to produce loss ratios commensurate with the loss ratios anticipated for the current premium for the applicable policies or certificates, with accompanying documentation sufficient to justify the adjustment, in the opinion of the Commissioner; and

ii. Make such premium adjustments as are necessary to produce an expected loss ratio for a policy or certificate in accordance with the appropriate loss ratio standards of (a) above, and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the carrier for such policies and certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described herein, shall be made at any time other than upon the policy renewal or anniversary date.

[(c) Every insurer may submit a rate increase for filing by the Commissioner whenever the expected aggregate loss ratio for the policy or certificate becomes greater than the anticipated loss ratio for that policy or certificate. The rate increase shall be such that, following the increase, the expected aggregate loss ratio shall not be less than the anticipated loss ratio. The anticipated loss ratio shall continue to meet the applicable standards of (a) above.]

[(d)]**2.** Every [insurer] **carrier** shall submit for filing by the Commissioner a rate reduction whenever the expected aggregate loss ratio reported for a policy or certificate is less than the anticipated loss ratio for that policy or certificate, and the requirements of [(b)] (c) above may not be met.

[(e)]**3.** When a rate adjustment is requested pursuant to a change in the policy or certificate necessary to eliminate benefit duplication with Medicare, the submission for a rate change shall include any riders, endorsements, policy and certificate forms needed to accomplish the Medicare supplement coverage modification necessary to eliminate benefit duplications with Medicare. All such forms shall result in a clear description of the Medicare supplement benefits provided by the policy.

4. If a carrier does not make premium adjustments acceptable to the Commissioner, the Commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the appropriate loss ratio.

(e) Carriers shall submit for filing with the Commissioner annually on or before May 31 reports in accordance with the reporting form contained in the Appendix to subchapters 16 and 23 of this chapter, Exhibit F, completed for each type in a standard Medicare supplement benefit plan.

1. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), a refund or credit calculation shall be required.

i. The refund calculation shall be done on a Statewide basis for each type in a standard Medicare supplement benefit plan.

ii. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

2. A refund or credit shall be made by carriers whenever the benchmark loss ratio exceeds the adjusted experience loss ratio, and the amount to be refunded or credited exceeds a de minimis level.

i. A refund or credit against premiums due shall be made no later than September 30 following the experience year upon which the refund or credit is based.

ii. Refunds and credits shall include interest accruing from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of the United States Department of Health and Human Services, which in no event shall be less than the average rate of interest for 13-week Treasury notes.

(f) The Commissioner may conduct a public hearing, in his or her discretion, to gather information regarding a request by a carrier for an increase in a rate for a policy or certificate form, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard of (a)

above. The determination of compliance shall be made without consideration of any refund or credit for such reporting period. Public notices of the hearing shall be in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

(g) For purposes of this section, premiums and claims shall refer to premiums and claims for insured residents of this State under a specific policy form. However, if the experience is based on fewer than 1,000 life years of exposure for residents of this State, then the premiums and claims shall be a weighted average of the premiums and claims for this State and national experience, where the weighting factor applied to the State experience is the square root of the ratio of "a" to 1,000 ("a" being the number of the life years of exposure).

11:4-[23.9]**23.12** Filing requirements for [out-of-State group] policies**, certificates and premium rates**

(a) No [insurer] **carrier** shall deliver or issue for delivery in this State any Medicare supplement policy or certificate, any written application therefor, or any printed rider or endorsements to be applied thereto, unless the forms thereof have been submitted to and filed by the Commissioner.

1.-4. (No change.)

(b) (No change.)

(c) No carrier shall use or revise premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been submitted to and filed by the Commissioner in accordance with (a) and (b) above.

(d) The Commissioner shall not file, and carriers shall not submit for filing, more than one Medicare supplement policy or certificate form of each type for each standard Medicare supplement benefit plan, except as the Commissioner may otherwise approve in accordance with (d)2 below.

1. For the purposes of this subchapter, "type" shall mean an individual policy, and a group policy, and at such time as a Medicare Select program shall become effective in this State, an individual Medicare Select policy, and a group Medicare Select policy.

2. The Commissioner may approve carriers, individually, to offer up to four additional policy or certificate forms of the same type for the same standard Medicare supplement benefit plan. Such forms shall be subject to the filing requirements of this section. The four additional policy or certificate forms of the same type shall be limited to one additional form of the same type for:

i. The inclusion of Innovative Benefits;

ii. The addition of either a direct response or an agent marketing method;

iii. The addition of either guaranteed issue or underwritten coverage; and

iv. The offering of Medicare supplement coverage to persons eligible for Medicare by reason of disability.

(e) A carrier shall not discontinue offering any policy or certificate form filed by the Commissioner on or after the effective date of this subchapter unless such form has been withdrawn from filing pursuant to (a)4 above, or the carrier provides notice of discontinuance of offer to the Commissioner at least 30 days prior to such discontinuance, in writing.

1. Discontinuance subject to notice to the Commissioner shall include the following:

i. Failure to actively offer for sale a policy or certificate form for more than 12 consecutive months;

ii. Sale or transfer of Medicare supplement policies or certificates to another carrier; and

iii. Revisions in the rating structure or methodology applicable to a Medicare supplement policy or certificate form which has not been otherwise submitted to and filed by the Commissioner in accordance with N.J.S.A. 11:4-23.11.

2. Carriers shall not submit for filing a new form for any Medicare supplement plan of the same type for which the carrier has discontinued issue of a policy or certificate for a period of five years following the notice of discontinuance to the Commissioner. The Commissioner may waive some or all of the five year period, in his or her discretion.

(f) Except for policies or certificates assumed under an assumption reinsurance agreement, the experience of all policy or certificate forms of the same type for a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation set forth at N.J.S.A. 11:4-23.11(d).

11:4-[23.10]**23.13** Compensation arrangements

(a) No [insurer] **carrier** or other entity shall provide to any producer a first year commission or first year compensation for the sale of Medicare supplement policies **or certificates** in an amount which exceeds 200 percent of the commission to be provided by that [insurer] **carrier** or other entity for the selling or servicing of that policy **or certificate** in the second year or period of that policy **or certificate.**

(b) The commission or other compensation which [shall] **may** be provided [for a reasonable number of] **in** subsequent renewal years shall be**, for no fewer than five renewal years,** the same as that commission or compensation provided in the second year or period.

(c) No [insurer] **carrier** or other entity shall provide compensation or commission to any producer, nor shall any producer receive commission or other compensation, greater than the renewal commission or compensation payable by the replacing [insurer] **carrier** on renewal policies or certificates when an existing policy **or certificate** is replaced [, except when benefits under the new policy are clearly and substantially greater than those of the replaced policy.]

(d) (No change.)

11:4-[23.11]**23.14** Required disclosure provisions

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

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

[2. Every insurer shall provide upon delivery of a policy or certificate information relevant to the premiums payable by the applicant to whom the policy or certificate was issued. This information shall appear on the schedule page of or as an attachment to the policy or certificate.]

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

i. (No change.)

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

[4.]**3.** A Medicare supplement policy **or certificate** [which provides] **shall not provide** for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import [shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage].

[5.]**4.** If a Medicare supplement policy **or certificate** contains any limitations with respect to preexisting conditions, such limitation shall appear as a separate paragraph in the policy **or certificate** and be labeled as ["Preexisting Condition Limitations," "Preexisting Condition Exclusions," or words of similar import.] **"Preexisting Condition Limitations."**

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

[7.]**6.** [Insurers] **Carriers** issuing policies or certificates which provide hospital or medical expense coverage on an expense incurred, indemnity, or service benefit basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide for delivery to all applicants an informational brochure, which is intended to improve the buyer's ability to select the most appropriate coverage, and to improve the

buyer's understanding of Medicare. Delivery of the informational brochure shall be made whether or not policies **or certificates** are advertised, solicited or issued as Medicare supplement policies **or certificates** as set forth by this subchapter. The full text of the approved guide appears as an Appendix to subchapters 16 and 23 of this chapter, Exhibit A, and is entitled "Bridging the Medicare Gaps: A Guide to Medicare Supplements."

[8.]**7.** To ensure uniformity in the content, form and printing of the guide, each [insurer] **carrier** shall comply with the following requirements:

i. [Insurers or] **Carriers and** their printers shall use only the printing negatives authorized by the Department of Insurance. Information concerning the purchase of the negatives is available from the Department of Insurance, Division of Public Affairs;

ii. (No change.)

iii. A chart entitled "Medicare Deductibles and Co-payments for 19__" shall be included in the back pocket of each guide. A sample copy of this chart appears as an Appendix to subchapters 16 and 23 of this chapter, Exhibit B. To ensure uniform design, content and printing of the chart, the Department of Insurance, Division of Enforcement and Consumer Protection, Senior Health Insurance Program, will provide sample copies of the chart to [insurers] **carriers** to the format of which [insurers must] **carriers shall** adhere exactly.

[9.] **8.** Except in the case of direct response [insurers] **carriers,** delivery of the guide shall be made to the applicant at the time of application, and acknowledgement of receipt of the guide shall be obtained by the [insurer] **carrier.** Direct response [insurers] **carriers** shall deliver the guide to the applicant upon request but [not] **in no instance shall delivery of the guide occur** later than the time of policy or certificate delivery.

[10.] **9.** Except as provided in (c) below, the terms "Medicare Supplement," "Medigap," and words of similar import shall not be used unless the policy or certificate is issued in compliance with N.J.S.A. 11:4-[23.6a] **23.8** and all other sections of this subchapter.

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

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

2. (No change.)

3. The outline of coverage provided to applicants pursuant to (b)1 above shall be in the [form] **language and format** prescribed [below:] **in Exhibit D of the Appendix to subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 12 point type. The outline of coverage shall consist of a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the carrier. All plans A through J shall be shown on the cover page, and the plan(s) offered by the carrier shall be prominently identified. Premium information for the plan(s) offered by the carrier shall be provided on the cover page, or immediately following the coverage page, clearly and prominently, specifying both the premium and the mode. All possible premiums for the applicant on all plans offered to the applicant by the carrier shall be illustrated.**

[(COMPANY NAME)
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION

Use this outline to compare benefits and premiums among policies.

1. Read Your Policy (Certificate) Carefully—This outline of coverage provides a very brief description of the important features of your Policy (Certificate). This is not the insurance (subscriber) contract and only the actual policy (contract) provisions will control. The policy (certificate) itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY (CERTIFICATE) CAREFULLY!

2. Medicare Supplement Coverage—Policies (Certificates) of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy (certificate). The policy (certificate) does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing, and taking medicines. (Delete if such coverage is provided.)

3.(i) For Agents:

Neither (insert company's name) nor its agents are connected with Medicare.

(ii) Direct responses:

(insert company's name) is not connected with Medicare.

4. (A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles, as appropriate), provided by the Medicare Supplement coverage in the following order.)

Description	This Coverage Pays**	You Pay
I. Minimum Standards		
PART A:		
INPATIENT HOSPITAL SERVICES:		
Semi-private room and board		
Miscellaneous hospital services and supplies, such as drugs, lab tests, x-rays, and operating room.		
BLOOD		
PART B		
MEDICAL EXPENSES		
Services of a physician/ outpatient services		
Medical supplies other than prescribed drugs		
BLOOD		
MISCELLANEOUS		
Immunosuppressive drugs		
II. Additional Benefits		
PART A:		
Part A deductible		
Private rooms		
In-house private nurses		
Skilled nursing facility care		
PARTS A & B:		
Home health services		
PART B:		
Part B deductible		
Medical charges in excess of Medicare allowable expenses (percentage paid)		
OUT-OF-POCKET MAXIMUM		
PRESCRIPTION DRUGS		
MISCELLANEOUS		
Respite care benefits		
Expenses incurred in foreign countries		
OTHER:		
TOTAL PREMIUM		

IN ADDITION TO THIS OUTLINE OF COVERAGE, (INSURER) WILL SEND YOU AN ANNUAL NOTICE, 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

**If this policy does not provide coverage for a benefit listed above, the insurer must state "no coverage" beside that benefit in the first column.

5. (Statement that the policy (certificate) does or does not cover the following:)

i. Private duty nursing;

ii. Skilled nursing care costs (beyond what is covered by Medicare);

iii. Custodial nursing home care costs;

iv. Intermediate nursing home care costs;

v. Home health care above number of visits covered by Medicare;

vi. Physician charges (above Medicare's reasonable charge);

vii. Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);

viii. Care received outside of U.S.A.;

ix. Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for or the cost of eyeglasses or hearing aids.

6. (A description of any policy (certificate) provisions which exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payments of the benefits described in section 4 above. Also, include conspicuous statements:

i. That the chart summarizing Medicare benefits only briefly describes such benefits;

ii. That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.

7. (A description of policy (certificate) provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium (subscription charge).)

8. The amount of premium (subscription charge) for the policy (certificate).]

(c) (No change.)

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

1. (No change.)

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

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

4.-6. (No change.)

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

11:4-[23.12]**23.15** Requirements for application forms and replacement coverage

(a) Application forms shall include **the following** questions designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any [accident and sickness or] Medicare supplement **or other health** policy or certificate in force, or is intended to be additional to any such policies or certificates. A supplementary application or other form to be signed by the applicant and agent [, except where coverage is not sold through an agent, containing such questions] may be used. [The questions shall be substantially as follows:] **In the case of a direct response carrier, a copy of the application or supplemental application, signed by the applicant and acknowledged by the carrier, shall be returned to the applicant by the carrier upon delivery of the policy or certificate. The application form or supplementary application form shall contain the questions and statements set forth below.**

1. Statements shall be as follows:

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

ii. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

iii. The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

iv. Counseling services may be available in your State to provide advice concerning your purchase of Medicare supplement coverage and concerning Medicaid.

2. Questions, numbered 1, 2, 3 and 4, shall be as follows and shall be prefaced by the statement "To the best of your knowledge":

[1.]i. Do you have another Medicare supplement policy or certificate in force, including any health care service contract or health maintenance organization contract?

ii. Do you have any other health insurance coverage that provides benefits which this Medicare supplement policy would duplicate?

(1) If so, with which company?

(2) What kind of coverage?

iii. If the answer to question 1 or 2 is yes, do you intend to replace these medical or health coverages with this policy (certificate)?

iv. Are you covered by Medicaid?

[2. Have you had any Medicare supplement policy or certificate in force during the last twelve (12) months?

i. If so, with which company?

ii. If the policy or policies lapsed, when did the lapse or lapses occur?

3. Are you covered by Medicaid?

4. Do you intend to replace any of your medical or health coverage with the policy or certificate for which you are applying?]

(b) (No change.)

(c) Upon [determining] **determination** that a sale will involve replacement **of Medicare supplement coverage,** [an insurer] **a carrier** or its agent[,] shall furnish to the applicant, prior to the issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of [accident and sickness] **Medicare supplement** coverage. One copy of such notice signed by the applicant and agent, except where coverage is sold without an agent, shall be provided to the applicant, and an additional signed copy shall be retained by the [insurer] **carrier.** A direct response [insurer] **carrier** shall deliver to the applicant at the time of the issuance of the policy (certificate) the notice regarding replacement of [accident and sickness] **Medicare supplement** coverage. [In no event, however, will such a notice be required in the replacement of "accident only" coverage.]

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

(e) The notice required by (c) above shall be **provided in** substantially **the form set forth in Exhibit E of the Appendix to Subchapters 16 and 23 of this chapter, incorporated herein by reference, in no less than 10 point type.** [as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS OR MEDICARE SUPPLEMENT COVERAGE

(Insurance Company's Name and Address)

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

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate accident and sickness

or Medicare supplement coverage and replace it with coverage issued by (Company Name). Your new (policy) (certificate) provides thirty (30) days within which you may decide without cost whether you desire to keep the coverage. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the protection available to you under the new policy.

You should review this new coverage carefully comparing it with all accident and sickness and other health coverage you may have, and terminate your present coverage only if, after due consideration, you find that purchase of this coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT, BROKER OR OTHER REPRESENTATIVE: (Direct solicitation insurers may delete the review statement.) (Use additional pages for comments as necessary.)

I have reviewed your current medical or health coverage. I believe the replacement involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

(1) (The following is to be included by all insurers.) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy whereas a similar claim might have been payable under your present coverage.

(2) (To be included by all insurers.) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time had partially or fully expired under the original policy.

(3) (To be included by all insurers.) If you are replacing existing Medicare supplement coverage, you may wish to secure the advice of your present insurers or its agent regarding the proposed replacement of your present policy. That is not only your right, it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(4) (To be included only if insurance is sold through an agent, broker or other representatives.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical/health history. Failure to include all material medical information on the application may provide a basis for the company to deny any future claims and to refund your premium (subscription charge) as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

(5) (To be included only by direct response insurers if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within thirty (30) days if any information is not correct and complete, or if any past medical history has been left out.

Signature of Agent, Broker or Other Representative
(Direct response insurers may omit this signature line.)

Typed Name and Address of Agent or Broker
(Direct response insurers may omit this line of identification.)

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

(Direct response insurers may omit the above signatory statement.)

Insurance Company Name

(f)] Item (1) of the notice set forth in [(e) above] **Exhibit E** may be omitted or modified if preexisting conditions are covered under the new coverage. **If the policy or certificate is guaranteed issue, item (3) of the notice in Exhibit E may be omitted.**

11:4-[23.13]**23.16** Filing requirements for advertising

(a) Every [insurer] **carrier** providing Medicare supplement policies **or certificates** in this State shall file with the Commissioner a copy of all advertisements to which residents of this State will have access, and through which the [insurer] **carrier** intends, or by implication purports to the reasonable targeted consumer its intent, to make its Medicare supplement product(s) available for purchase or enrollment in this State, whether through written, radio, television or other electronic media, at least 30 days prior to the date on which the advertisement is to be used in this State, or made accessible to residents of this State.

(b) All advertisements shall be in accord with the standards set out in N.J.A.C. 11:2-11 and any other disclosure and advertising rules which may be applicable to [insurers] **carriers.**

(c) (No change.)

(d) The Commissioner may institute any and all procedures and penalties available pursuant to the Medicare Supplement Acts of this State and the Trade Practices Act, N.J.S.A. 17B:30-1 et seq., against [an insurer who] **a carrier which** is determined by the Commissioner to be in violation of this rule.

(e) (No change.)

11:4-[23.14]**23.17** Standards for marketing

(a) Every [insurer or other entity marketing Medicare supplement coverage in this State] **carrier**, directly or through its producers, shall:

1. (No change.)

2. Establish marketing procedures to assure excessive [insurance] **coverage** is not sold or issued to any consumer;

3. Establish procedures for determining whether a replacement policy contains benefits clearly and substantially greater than the benefits provided under the replaced policy and thereby institute guidelines as to when first year commissions or replacement commissions are appropriate pursuant to N.J.A.C. 11:4-[23.10]**23.13**;

4. Display prominently by type, stamp or other appropriate means, on the first page of the [outlines of coverage] **policy or certificate** the following:

"Notice to buyer: This policy may not cover all of [the costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations] **your medical expenses.**"

5.-6. (No change.)

(b) Practices which are prohibited in this State, in addition to those set forth in the Trade Practices Act, N.J.S.A. 17B:30-1 et seq., include, but are not limited to, the following:

1. Twisting; that is, knowingly making any misleading representations or incomplete or fradulent comparisons of any policies or [insurers] **carriers** for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convey any policy **or certificate** or to purchase any policy or certificate with another [insurer] **carrier**;

2. (No change.)

3. Cold lead advertising; that is, making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance **or other similar coverage,** and that further contact with the consumer will be made by an insurance agent**, other producer** or [insurance company] **carrier**.

11:4-[23.15]**23.18** Appropriateness of recommended purchase and excessive coverage

(a) (No change.)

(b) Any sale of Medicare supplement coverage which will provide an individual with more than one Medicare supplement policy or

certificate is prohibited[; however, additional Medicare supplement coverage may be sold to an individual if, when combined with that individual's health coverage already in force, the individual if, when combined with that individual's health coverage already in force, the individual would receive coverage of no more than 100 percent of the individual's actual medical expenses allowable under the combined policies].

11:4-[23.16]**23.19** Reporting of multiple policies

(a) Every [insurer] carrier shall report annually, on or before March 1, to the Commissioner, the policy and certificate number and date of issuance of each policy or certificate, grouped by individual [policyholders] **insureds** for every individual resident of this State for which the [insurer] **carrier** has in force more than one Medicare supplement policy or certificate.

(b) Carriers shall submit reports of multiple policies on a form substantially similar to that form set forth in Exhibit G of the Appendix to Subchapters 16 and 23 of this Chapter, incorporated herein by reference. Carriers shall submit separate forms for each insured for which multiple policies or certificates are being reported. No form shall contain information relevant to more than one insured. In any instance in which one form provides insufficient reporting space for an insured's policies or certificates, additional pages should be attached containing the additional information.

11:4-23.20 Addresses for submissions for filing

(a) All forms, rates, loss ratio reporting and advertisements submitted for filing with or by the Commissioner shall be submitted to the Division of Life and Health Actuarial Services, New Jersey Department of Insurance, CN 325, Trenton, New Jersey 08625-0325, directed to specific bureaus as follows:

1. Health Care Plan Bureau, for submissions from health maintenance organizations and such other similar entities;

2. Service Corporation Bureau, for submissions from health, hospital and medical service corporations; and

3. Statutory Compliance Bureau—Health, for submissions from all other carriers.

(b) Annual reports of multiple policy issues submitted for filing with the Commissioner shall be submitted to the Division of Legislative and Regulatory Affairs, New Jersey Department of Insurance, CN 325, Trenton, New Jersey 08625-0325, to the attention of Medicare Supplement Multiple Policy Report.

11:4-23.21 Penalties

Failure to comply with the terms of this subchapter may result in the assessment of any and all penalties available in accordance with the laws of this State.

11:4-[23.17]**23.22** (No change in text.)

APPENDIX TO SUBCHAPTERS 16 and 23

EXHIBIT A

BRIDGING THE MEDICARE GAPS:
A GUIDE TO MEDICARE SUPPLEMENTS

INTRODUCTION

Medicare. The word can be both a comfort and a puzzle. A comfort because Medicare is a program which provides good, basic health coverage at minimal cost. A puzzle because the program's structure makes it look harder to understand than it really is.

Medicare historically has paid a relatively stable share of health care costs for older citizens, ranging from about 40 percent in 1977, 45 percent in 1984 and 40.1 percent in 1988, according to the U.S. House of Representatives Select Committee on Aging.

But health care costs have been rising faster than inflation—which means higher medical bills. So even though older people have been paying a relatively constant percentage of their medical bills, the bills themselves are larger. The bottom line is that older citizens are paying more total dollars for their share of health care costs.

Before making a decision about [what kind of] **which** insurance **policy** to buy **to supplement Medicare,** everyone should **do two things. First, know what Medicare does and does not cover. Second,** assess his or her own needs **and financial situation.**

Assessing the need for additional protection is easier if one understands the basic structure of Medicare. The first section of this booklet is designed with that in mind. The rest of this booklet will tell you what other types of insurance are available to fill some of Medicare's gaps.

MEDICARE

What Is It?

Medicare is a federal health insurance program for people 65 or older, people of any age with permanent kidney failure, and certain disabled people under age 65. The program is administered by the Health Care Financing Administrative (HCFA) of the U.S. Department of Health and Human Services. The Social Security Administration provides information about the program. Persons who are not automatically enrolled in Medicare may enroll at their local Social Security Office.

[BASIC STRUCTURE OF MEDICARE] **Basic Structure of Medicare**

Medicare coverage comes in two parts—Part A, hospital insurance, and Part B, medical insurance.

The two parts of the program parallel the divisions in the medical community between hospitals and physicians. Although hospitals are filled with doctors, few doctors actually work for hospitals. Most physicians are independent business people. So, if you go to the hospital with the flu, you receive separate bills—one for the things the hospital provides such as a room, nurses, food and drugs; and another for the doctors who treat you. Similarly, Medicare has two parts—A, which pays inpatient hospital bills, and B, which pays doctors' bills and other outpatient medical expenses.

Part A, the hospitalization portion of Medicare, is [free, and most senior citizens participate automatically] **funded through employee contributions to FICA taxes. This amount goes into the Part A trust fund and pays for the Part A premiums for most people. A very small percentage of seniors must purchase Part A and pay a monthly premium. Persons already receiving monthly Social Security or Railroad benefits receive their Medicare card automatically. All others must file an application in order to be covered by Medicare.**

Part B, the medical portion, requires a monthly premium, which, for most people, is deducted from the Social Security check. You're automatically enrolled in Part B when you enroll in Part A, unless you specifically state you don't want it. If you choose not to enroll in Part B you sign up for Medicare, you can join **this protion of the** program later. [But] **However** if you wait, the premiums [will] **may** be higher **if either you or your spouse is not working and enrolled in an employer group health plan.** If you wait because you're still working and you're still covered under your employer's group health plan, you will not have to pay the higher Part B premium when you do sign up **as long as you sign up within seven months of the date when employment ceases.**

Each of the two parts has a deductible, an amount of money which you have to pay before Medicare starts paying.

Each also require a co-payment, a part of each bill you're required to pay.

And each has its own rules about when these payments are required. The specific dollar amounts can change from year to year. The chart in the back pocket of this booklet shows this year's deductible and co-payment amounts.

Medicare Part A—Hospital Insurance

The hospital insurance portion of Medicare, Part A, pays hospital room and board fees. It also pays for some goods and services (such as laboratory costs, physical therapy and [drugs] **prescription medications**) while you're a patient in the hospital.

Part A does not cover all hospital bills. It covers a portion of them, depending on how long you are in the hospital and on the basis of benefit periods (see page ____.)

Drawn on a graph like the one on page ____, the system resembles a three-step staircase. First you pay the Part A hospital deductible (which is roughly equal to the average national cost of one day in a hospital).

Then, for 60 days, Medicare pays 100 percent of the covered hospital expense.

After 60 days, you take the first step down. For days 61 through 90, Medicare covers most of the hospital bills, but you have to pay a co-payment for each day you're there. (The co-payment is about 25 percent of the average national cost of a day in the hospital.)

If, after the 90 days, you're still in the hospital, you have to make a decision. You either begin playing all the hospital bills yourself, or you take a half-step and dip into the lifetime reserve days that Medicare provides.

Your lifetime reserve is a "bank" with 60 days of partial coverage. The daily co-payment rises to about 50 percent of the average national daily hospital charge. You can use all or some of the 60 days for any hospitalization between 91 and 150 days. Once you use up all 60 lifetime reserve days, however, you can't get them back.

Although the increases in co-payments may seem steep, the odds of experiencing a prolonged hospital stay are small. Only 2 percent of Medicare subscribers exhaust their coverage in any given year, according to [the U.S. Health Care Financing Administration] **HCFA.** And national statistics indicate that the average hospital stay for a person [over 65 has been ranging between 7.5 and 11] **on Medicare is approximately 14** days.

What Part A Also Covers

Medicare also pays for three of the newer, less expensive alternatives to hospitalization—skilled nursing facility care, home health care and hospice care.

Let's say you've had a stroke and have been in the hospital for several weeks. You no longer need the intensive care a hospital provides, but you do need [daily rehabilitation] **rehabilitative** therapy **on a daily basis** before going home. Your doctor may refer you to a skilled nursing facility, where you will get professional nursing care and rehabilitation services. Although there are some restrictions, Medicare will generally pay all the facility's bills for the first 20 days and a portion of the bills for days 21 through 100, providing the care is reasonable and necessary.

Medicare will also pay for **covered** home health care **services,** [to help you leave a hospital or skilled nursing facility] if your condition meets certain requirements, among them a need for part-time skilled nursing care [or], **physical** therapy **or speech therapy while homebound.**

In addition, Medicare covers hospice care for terminally ill patients who want to stay home during their final weeks of life. Hospices (special organizations which help dying patients and their families) will supply doctors' services, nursing care, home health aides, homemaker services, counseling, and medical appliances and supplies. There are some restrictions and some minimal co-payments for a few services, but Medicare will pick up the majority of the bills.

How Often Can You Collect?

Medicare Part A pays hospital expenses on the basis of benefit periods. A benefit period starts when you enter a hospital and ends when you have been out of the hospital or skilled nursing facility for 60 days in a row.

Benefit periods determine whether you have to pay a deductible and how much of the hospital bill Medicare will pay. Let's say, for instance, that you were in the hospital 60 days, went home for two weeks and then went back to the hospital for another two weeks. You would only have to pay one deductible because both hospitalizations occurred in the same benefit period. You would, however, have to pay a co-payment for each day of the two weeks you were hospitalized the second time, because you exhausted your 100 percent coverage during the first 60 days of the benefit period.

When Will Medicare Refuse to Pay?

There are several levels of nursing home care. Medicare **only** covers [time] **services at the skilled level** in skilled nursing **care** facilities, which are sometimes called nursing homes. But Medicare does not cover **intermediate** or custodial [nursing home] care [that] **levels, which** provides only **intermittent professional care or only** a place to live and help with personal needs such as bathing, feeding, dressing and taking medicine.

Usually Medicare pays hospitalization, skilled nursing facility and home health agency fees only when the facility or agency is Medicare-approved. Although all New Jersey hospitals are approved, some hospitals and treatment centers in other states may not be. And even if a skilled nursing facility or home health agency is licensed by the state, it may not be Medicare-approved.

Medicare may also refuse to pay for experimental or controversial procedures.

Except under certain very limited conditions in Canada and Mexico, Medicare will not cover care received outside the United States.

If you plan to travel, or if you're not sure whether the treatment or hospital you are considering has Medicare approval, check ahead of time with your Social Security Office to see if benefits are available.

Medicare Part B—Medical Insurance

Medicare Part B, medical insurance, is the section that helps to pay your doctor, whether you are in or out of the hospital. It also serves as a catch-all for the wide-range of services people use when they are not patients in hospitals—outpatient visits to hospitals, physical therapy, laboratory tests, medical equipment (like wheelchairs or oxygen), and medically necessary home health visits.

The medical insurance portion, Part B, has an annual deductible, an amount which you must pay once each year before Medicare will pay any bills related to Part B. The [deductible can change, so the] chart in the pocket on the back page shows the **deductible** amount for this year.

How Much Does It Pay?

The medical insurance portion of Medicare was designed to pay 80 percent of the cost of most covered services. You pay the other 20 percent, which is the Part B co-payment.

[You] **However, you** could wind up paying more than 20 percent. Fees charged by doctors, therapists, suppliers and hospitals may vary, even within one town. But Medicare has a fixed schedule of fees, known as the "approved amount," for procedures done in your area. Medicare will pay only 80 percent of the approved amount. So, if your bill from the doctor or hospital outpatient clinic is higher than the approved amount, you [must pay] **are responsible for** the difference.

Example: Suppose the Medicare-approved amount for a medical procedure is **[$40] $100,** but your doctor charges you [$50] **$110.** Medicare will pay 80 percent of the [$40] **$100** approved amount, or [$32] **$80;** you pay the 20 percent co-payment, or [$8] **$20.** But you also **must** make up the difference between the [$50] **$110** bill and Medicare's [$40] **$100** approved amount ($10). So the total out-of-pocket cost to you is **[$18] $30.**

Some doctors "accept assignments." This means the doctor agrees to accept the Medicare-approved amount for the services provided. You still have to pay the 20 percent co-payment, or [$8] **$20.**

Some doctors accept assignment some of the time, some accept it all the time, while others never accept it at all. Find out, before treatment, whether your doctor will accept assignment. Each year, doctors and medical service suppliers can sign agreements to become Medicare-participating doctors or suppliers. This means they agree in advance to accept assignment for all Medicare claims. The "Medicare-Participating Physician/Supplier Directory", which is available in Social Security offices and county Offices on Aging, gives the names and addresses of Medicare-participating doctors and suppliers. You can also get this **free** diretory from Pennsylvania Blue Shield, the Medicare carrier for New Jersey.

For a detailed description of the Medicare program, ask your local Social Security office for a free copy of "Your Medicare Handbook."

FILLING IN THE GAPS

By now you are aware that Medicare coverage has three general gaps:

1. the deductibles and co-payments;

2. the difference between what Medicare pays and what the doctor charges; and

3. the services Medicare doesn't cover at all (for example: most nursing home care, prescription drugs, hearing aids, care outside the U.S.).

[You can bridge the gap's in Medicare] **People try to fill these gaps** in a variety of ways. [But there are choices to make.] **Below you'll read about some of the kinds of insurance consumers purchase in an attempt to plug these holes, but first it is important to note that since** [Different] policies tend to plug different holes in the Medicare program, [so you probably won't] **it isn't likely you**

will find one policy, **or a combination of policies,** that [pays for all your health care costs] **will fill all of Medicare's gaps.**

The word "medigap" is an umbrella term. This means that it doesn't refer to any one specific type of policy, but rather to several kinds of insurance that may help to fill in some of the gaps of Medicare. Following are seven different kinds of coverage that consumers often consider adding to their Medicare coverage.

To decide which policy suits you best, begin by evaluating your needs and financial circumstances. How much you can afford to pay for insurance? Do you want first dollar coverage that will help pay Medicare's deductibles and co-payments? Or are you more concerned about covering things that Medicare does not—for example, doctors' bills that go beyond the Medicare-approved amount or care outside the United States? Will you find it easier to budget regular insurance payments than to worry about later medical bills you might not be able to pay?

Medicaid

For some people, paying even small amounts of medical expenses or another health insurance policy may be a real hardship. If you are one of them, check with your [local] Social Security [office] **Office** or [the state or] County **Board of Social Services/Welfare Agency** to see if you are eligible for Medicaid a free health care program for low-income people funded by the state and federal governments.

Although the combination of Medicare and Medicaid pays many of your health care costs, you should consider the following points before dropping any Medicare supplement policy you may already have:

1. a Medicare supplement policy may cover services not paid by Medicaid, such as private duty nursing, care outside the United States, a private room in a hospital;

2. if your Medicaid eligibility ends, you may have a six month waiting period before a new policy will pay benefits for health conditions you already have:

3. if you enter a nursing home, Medicaid will pay the premium for your Medicare supplement policy;

4. if you cancel Medicare supplement coverage that has been available to you at no charge as a retirement benefit or through your spouse, it may not be renewable if you no longer qualify for Medicaid[.]; **and**

5. recent federal legislation now requires insurers to suspend Medicare supplement insurance benefits and premium payments for up to a 2-year period upon the request of the policyholder during the policyholder's entitlement to benefits under Medicaid, and to reinstate these insurance benefits upon request of the policyholder when Medicaid entitlement ends.

New Jersey also has a variety of health care programs available to certain needy residents who may not qualify for the traditional Medicaid Program. Each program has its own eligibility requirements. Contact your County Welfare Agency or Board of Social Services to see if you qualify for any of the following:

New Jersey Care
Medically Needy
Community Care Program for the Elderly and Disabled (CCPED)
AIDS Community Care Alternative Program (ACCAP)

Prescriptions and Hearing Aids

New Jersey has a program that will help pay for prescription drugs, and another that will help pay for hearing aids.

The Pharmaceutical Assistance to the Aged and Disabled (PAAD) Program helps pay for prescription medicines and some pharmacy items such as insulin syringes and needles.

The Hearing Aid Assistance to the Aged and Disabled (HAAAD) Program reimburses $100 to eligible residents of New Jersey who buy a hearing aid.

To qualify for PAAD or HAAD, you must be at least 65 or be receiving Social Security Disability and you must meet certain income limits. The limits, which are higher than those for Medicaid, can change.

For more information about each program call the toll-free hotline at (800) 792-9745.

What Does Your Employer Offer?

The ideal time to start thinking about how you will supplement Medicare is several months before you reach age 65, particularly since you may be able to take advantage of insurance coverage you have as an employee.

If you are covered by a health plan at work, your employer may allow you to remain insured under the group plan after you retire and continue to pay all or part of the premium. This is sometimes referred to as "continuation."

Your employer may offer a different arrangement called "conversion." This permits you to buy an individual policy from the same insurance company you had at work, but doesn't necessarily mean your new policy will have the same benefits. Nor does it mean the policy will be cheaper than similar policies you may find by shopping around on your own.

Continuation and conversion offer two advantages: you will probably not be required to produce a medical history or undergo a medical examination; and, you will not have to wait to receive benefits.

One kind of insurance you may be able to keep through continuation or conversion is a major medical policy.

As the name implies, major medical coverage is designed to cover very large medical bills, usually after you have paid a substantial deductible. The deductibles [may] **for major medical can** be as high as $1,000 **or more, depending on the policy,** but the coverage can amount to as much as $1 million.

Continuation of a major medical plan through a former employer may help pay for some costs after Medicare stops paying or for costs Medicare will not pay at all—for example, medical bills that exceed the Medicare allowed amount.

There are no hard and fast rules, about continuation or conversion policies. Ask your employer's personnel office to explain your options. Can you continue or convert? How much will the coverage cost? Will the policy cover your spouse? (Some do and some don't.) What will the policy pay for?

Health Maintenance Organizations

Membership in a health maintenance organization—HMO—is another way to fill the gaps in Medicare. HMOs are prepaid health care programs. Like insurance policies, HMOs cover certain health care costs. Unlike insurance policies, HMOs actually provide health care services. Some HMOs have [contracts] **a contract** with Medicare. As a Medicare beneficiary, you're eligible to join an HMO if you participate in [at least Part B] **both Parts A and B** of Medicare and live in a county where an HMO that contracts with Medicare is available. **Persons with Part B only of Medicare are also eligible to enroll in a Medicare-contracting HMO, however, coverage is limited.**

If you join an HMO, you don't have to pay the Medicare deductibles or co-payments or file claims. You pay a monthly premium to the HMO, which provides doctor's services and most other health care. You may have to pay a co-payment of $1 to $10 for some services.

The trade-off is that you have to use the HMO **participating** doctors **and facilities.** If you need a specialist, you must go to one recommended by the HMO. If you choose to see a non-HMO physician on your own, you **will** have to pay **all or some of** the bills yourself.

HMOs can have one of two types of contracts with Medicare: either a "cost" or a "risk" contract. You should learn which type of contract the HMO has with Medicare before enrolling.

Members of an HMO having a cost contract with Medicare have a bit more flexibility with regard to reimbursement when they go outside the HMO network. The reason is that when Medicare has a cost contract with an HMO it will still pay 80 percent of its approved amount for services rendered to a member out of the HMO network.

When Medicare has a risk contract with an HMO, however, it will not pay any portion of the bill for services received outside the HMO network except under very specific circumstances (for example, life-threatening emergencies).

There are different kinds of HMOs. Some have all their doctors located in facilities owned by the HMO. Some are networks of physicians who maintain their own offices and service HMO patients as a part of their regular practice.

HMO plans and premiums vary. A "low option" HMO plan generally covers at least the services included under the regular Medicare program. A "high option" plan ususally includes additional services not covered by Medicare, for example, eye care.

For further information on Medicare-contracting HMOs, write the New Jersey Department of Insurance, Enforcement and Consumer

Protection, Senior Health Insurance Program, CN 325, Trenton, NJ 08625.

Medicare Supplement Policies

If you are looking for a policy specifically designed to coordinate with Medicare, you may want to consider a Medicare supplement policy. The phrase "Medicare supplement" is a special term reserved in New Jersey for policies that meet minimum standards set by the state. [Most policies sold to individuals are required to cover at least:

- the Part A hospital co-payment amounts;
- 90% of hospital expenses after 250 days (when Medicare runs out) up to a total 365 days;
- 20% of Medicare's approved amounts under Part B subject to a maximum calendar year deductible of $75;
- the reasonable cost of the first three pints of blood.

Medicare supplement policies vary widely in price, depending on what they cover. Some supplements, for example, also cover a part of private duty nursing care, prescription drugs and the Part B deductible. Generally, the more comprehensive the coverage, the more expensive the policy will be.]

Because people looking to purchase health insurance coverage to supplement Medicare come from varying backgrounds, there is no one "best" policy for everyone. Coverage should be purchased only after an individual has assessed what he or she can afford to pay, and what his or her individual needs and wants are in the way of insurance benefits.

For example, someone who can only afford to pay $50 per month for a policy has already eliminated any plan that costs over that each month and will need to choose from those plans available in his or her price range.

Also, just because an individual can afford a $100 per month policy does not mean he or she should not consider a less expensive policy. If the more expensive plan contains one or more benefits the person does not want, (for example, Care Outside the United States and At-Home Recovery) then a less expensive plan without these benefits may be a better buy.

Until recently, there were hundreds of Medicare supplement policies being sold throughout the country. The benefits provided by these policies varied greatly, which created much confusion on the part of consumers. In 1990, however, the federal government, under the OBRA '90 law, made a move to consolidate the number of Medicare supplement policies being sold. This resulted in the approval of 10 policy designs, which simplifies the process of selecting a policy by consumers.

Plan A is known as the "Core" plan, and all of its benefits are found in each of the other nine plans, B through J, as well.

The Core plan's benefits pay for:

—Part A co-payments: days 61-90 in a hospital;
days 91-150 in a hospital;

—100% of hospital expenses after 150 days (when Medicare runs out), up to a total of 365 days in a lifetime;

—Part B co-payments: 20% of Medicare's approved amount; and

—Costs for the first three pints of blood each year.

In addition to the Core plan benefits, plans B through J include various other benefits, such as coverage for the Part B deductible, prescription drugs and preventive health care.

The 10 Medicare supplement policy designs, A through J, are shown in the following chart:

	PLANS									
BENEFITS	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
CORE BENEFITS—Part A copayments, Part B copayments, three pints of blood replacement	x	x	x	x	x	x	x	x	x	x
PART A DEDUCTIBLE—All of the inpatient hospital deductible amount per benefit period.		x	x	x	x	x	x	x	x	x
PART B DEDUCTIBLE—All of the deductible amount per calendar year regardless of hospital confinement.			x			x				x
SKILLED NURSING FACILITY CARE—All of the Medicare copayment amount for days 21-100 in a benefit period			x	x	x	x	x	x	x	x
MEDICALLY NECESSARY EMERGENCY CARE IN A FOREIGN COUNTRY—80% of the billed charges subject to a calendar year deductible and a lifetime maximum benefit.			x	x	x	x	x	x	x	x
AT-HOME RECOVERY—Up to seven (7) visits per week for a maximum calendar year benefit of $1600, for assistance with activities of daily living.				x			x		x	x
PREVENTIVE MEDICAL CARE—Up to the Medicare-approved amount for specified services for a maximum amount of $120 per calendar year.					x					x
100% OF PART B EXCESS CHARGES—All of the difference between the Medicare-approved amount and appropriate billed charges.						x			x	x
80% OF PART B EXCESS CHARGES—80% of the difference between the Medicare-approved amount and appropriately billed charges.							x			
BASIC OUTPATIENT PRESCRIPTION DRUGS—50% of charges subject to a calendar year deductible and a per year per insured maximum.								x	x	
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—50% of charges subject to a calendar year deductible and a per year per insured maximum (exceeding the Basic Outpatient Prescription Drugs maximum).										x

New Jersey law allows all 10 plan designs to be sold in the state. Consumers, however, may not find all 10 plan designs available to them. The reason is that insurance companies selling Medicare supplement policies have an option of which plans, if any, they would like to sell. If an insurance company does choose to sell one or more Medicare supplement policies, the Core plan must be one of these plans.

The Department of Insurance maintains a list of the individual Medicare supplement polices for sale in New Jersey. [The list is updated each year.] If you need a copy of the list, send a self-addressed, stamped envelope to the Department of Insurance, Enforcement and Consumer Protection, Senior Health Insurance Program, CN 325, Trenton, New Jesey 08625.

Limited Benefit Policies

Policies that do not pay all the benefits or do not pay the dollar amounts of the benefits that are required of Medicare supplement policies are called "limited benefit" policies.

These plans can provide some limited coverage when added to your Medicare insurance. However, the coverage provided is not considered adequate to fill gaps in Medicare.

Limited benefit policies that are designed to be added to your Medicare coverage may be called by different names, which may be confusing to an uninformed consumer. These plans may be referrred to as "complements" or "supplemental" policies—different than Medicare supplement policies.

Advertising literature for this kind of insurance coverage may be misleading in that a consumer may believe that the policy adequately covers the gaps in Medicare; however, coverage is generally limited to in-hospital services.

In some policies, both in-patient and out-patient coverage may be available, but benefits are usually limited to eligible services and/or limited amounts payable per calendar year.

These policies are often less costly than most Medicare supplement policies and therefore may be attractive to Medicare beneficiaries looking to purchase additional insurance coverage. If you can afford a Medicare supplement policy, there is no need to have a "limited benefit" policy.

Examples of limited benefit policies are discussed below.

Blue Cross and Blue Shield Coverage

Blue Cross and Blue Shield of New Jersey, Inc., [is] a non-profit health service corporation [offering three individual], **offers two limited benefit** plans designed to coordinate with Medicare. [However, only one of the three plans meets New Jersey's minimum standards for Medicare Supplements.

Super 65

Blue Cross and Blue Shield Super 65 meets New Jersey's minimum standards for Medicare supplements. It pays the Part A deductible and Medicare's hospital co-payments. After 150 days in a hospital when Medicare stops paying, Super 65 covers 100 percent of Medicare eligible expenses for an unlimited number of days. It pays the Part B deductible, 20 percent of Medicare's allowed amounts for doctors and other out of hospital services without any dollar maximums. Super 65 covers the cost for care received outside the United States. You may enroll in Super 65 any time during the year. However, there is a six month waiting period for preexisting conditions.

The following two plans are "limited benefit" policies because they do not pay all the benefits, or the dollar amounts of the benefits are less than what we require of Medicare supplements:

65]

Blue Cross and Blue Shield 65 is designed to provide basic hospitalization coverage. It pays the Part A deductible and co-payments, and costs for care outside the United States. It also pays the Part B deductible and 20 percent of Medicare's approved amount for doctors who see you while you're hospitalized. Blue Cross and Blue Shield 65 pays 20 percent co-payments for some services outside a hospital but there are annual dollar maximums. It does not pay for hospitalization after 150 days (when Medicare runs out) and it does not cover physician home or office visits.

[65 SELECT]

Blue Cross and Blue Shield 65 Select is primarily aimed at covering the costs for a long hospital stay. You pay the everyday health care costs—the Part A and B deductibles and some medical co-payments—yourself. 65 Select [will pay] pays the Part B co-payment for physician care in the hospital, the Part A hospitalization co-payments, and 90 percent of hospital costs after Medicare runs out. It pays for some services performed outside a hospital, subject to annual dollar maximums, and for health care costs while traveling outside the United Staes. 65 Select does not cover physician home or office visits.

You can apply for Blue Cross and Blue Shield 65 or 65 Select within 31 days of your 65th birthday, or your Medicare effective date if you're disabled. If more than 31 days have passed since your 65th birthday, you can apply during the open enrollment period from February 1 through April 30 of each year. Your coverage will take effect on July 1.

Hospital Indemnity Policies

Frequently advertised by celebrities, indemnity policies pay a fixed amount of money per day, week or month while you are in the hospital. They are not designed, however, to fill Medicare's gaps.

The advantages are that they pay you regardless of whether you have other hospital coverage, and the money is yours to spend as you see fit.

The disadvantage is that they pay only if you're hospitalized. No matter what your medical bills are, you can't collect unless you're in the hopsital.

And depending on the policy you choose, you many not collect much even then: Under New Jersey's minimum standards, policies must begin paying by day four of your hospital stay. But they don't have to pay before the fourth day, so if you go home after three, you may not see a dime. Some policies stop paying after 31 days.

[The other thing to be careful about is that] **Other things you should be aware of are** the payments made to you may be much lower than your bills—even though policies sold in New Jersey are required to pay at least $40 a day[. Also]**; and**, the amount of the benefit can remain the same year after year, so unless you update your coverage occasionally, inflation will take its toll on the value of the payments. If you do buy a hospital indemnity policy, try to update it every few years.

Don't buy a hospital indemnity policy as your only additional health coverage to supplement Medicare.

Accidents Only

Accident-only policies provide coverage for death, dismemberment, or hospital and medical care due to an accident. They are not designed to pay routine health care costs. Since Medicare pays regardless of whether the reason for medical attention is an illness or an accident, it is very likely that having one of these policies is a duplication of benefits you already have.

Specified Disease Policies

You may have received advertisements in the mail for "dread-disease policies"—policies that will cover you for specific diseases, like cancer. They are such a bad buy that they are banned for sale in New Jersey, buy may still be accessible to some consumers as members of an organization headquartered outside this state.

Specified disease policies are a bad buy because they pay in so few situations that odds are heavily stacked against the company ever paying you anything.

As with accident-only policies, it is very likely that a specified diesease policy duplicates benefits which are ordinarily covered under Medicare. Since specified disease policies generally only pay for services related to the specific disease for which they were designed, you would have more comprehensive coverage with Medicare and a Medicare supplement policy.

Long Term Care Policies

Long-term care refers to a wide range of medical and non-medical services people need for a long period of time due to a chronic illness, disability, or physical or mental handicap. Long-term care can be provided in a nursing home, at home or in a community facility, **such as an adult day care center.**

Long-term care insurance policies cover different levels of nursing home care—skilled, intermediate, and custodial. Some will also help pay for alternatives to nursing home care: for example, home care and adult day care.

Before you buy a long-term care policy, be sure to read the policy provisions carefully. Will the policy pay benefits for skilled, intermediate and custodial nursing home care? Will it cover home health care? What is the definition for each level of care? Is there a waiting period (a period of time you have to be in the nursing home or receive home care before the policy will pay benefits)? Does the policy specifically exclude cov-

erage for any conditions? How long will the policy pay benefits? Under what conditions can the company cancel or refuse to renew the policy?

Long-term care insurance is generally purchased to fill some additional gaps in Medicare which are not filled by your other supplement coverage. It should be purchased only after you have adequate supplement coverage under another type of health insurance plan.

For a copy of our "Buyer's Guide to Long-Term Care Insurance", send a self-addressed legal size envelope to: Long Term Care Buyer's Guide, Public Affairs Division, Department of Insurance, CN 325, Trenton, New Jersey 08625.

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Accident-only policies provide coverage for death, dismemberment or hospital and medical care due to an accident. They are not designed to pay routine health care costs.

Specified Disease Policies

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Specified disease policies are a bad buy because they pay in so few situations that odds are heavily stacked against the company ever paying you anything.]

AUTO INSURANCE (PERSONAL INJURY PROTECTION)

Most New Jersey residents now have the option of selecting their health coverage provider, rather than their auto insurance company, to pay for their no-fault medical expense claims. Note:

> **Medicare and Medicaid will NOT provide primary coverage. If your primary health benefits are provided by either Medicare or Medicaid, you cannot choose this option. Medicare will only consider payment of claims after you have submitted them to the primary carrier(s).**

[Be An Educated Consumer] **BE AN EDUCATED CONSUMER**

Now that you know what Medicare does not cover, and what kind of policies are out there, you are ready to set your strategy.

If you're concerned about day-to-day expenses, look for a policy that pays in as many situations as possible. Generally speaking, your money would be better spent on something like a Medicare supplement policy which covers a broad spectrum of medical expenses than on a hospital indemnity policy which pays only a small [portion of the total daily hospital cost] **amount for days you spend in the hospital, but nothing toward your actual hospital or medical bills.**

Don't duplicate coverage. **It is a federal crime for someone to knowingly sell you a policy that duplicates Medicare or any private health policy you already have.**

If you already are covered under more than one health policy you should review these for duplication of benefits. It's better to [buy] **have** the most comprehensive policy you can afford than several policies that duplicate coverage. Some policies will not pay for an expense already covered under another policy. So if you [buy] **have** two of the same kind of policy, you can wind up with two sets of payments but only one set of benefits. [It is a federal crime for someone to knowingly sell you a policy that duplicates Medicare or any private health policy you already have, but that will not pay costs covered by another insurance policy.

If you have a good basic supplement policy and want to add a hospital indemnity policy to it, be sure to update the coverage every few years so that inflation doesn't erode the value of the coverage.]

Watch Out for Key Phrases

Policies are contracts, and like other legal documents, they use special vocabulary, including:

Waiting Periods[,]. If you're buying a new policy, you may have to wait up to 30 days before you will be eligible to collect anything. Some policies also have waiting periods of up to six months for specific conditions (for example, varicose veins) unless the conditions are considered a medical emergency and treated as such.

[If you're considering converting or continuing your employee coverage, you are less likely to have a waiting period. If you're thinking about buying a new policy, don't rush out and cancel an existing policy. Keep the old policy until the new one begins paying benefits.]

Preexisting Condition Exclusions. Policies may not pay bills for a health condition you had before you bought the policy. This usually isn't a problem with coverage extended by employers, and in New Jersey, Medicare [supplements] **supplement policies** must pay for any conditions after you've had the policy for six months. But policies that are not [called] Medicare [supplements] **supplement policies**, such as hospital indemnity policies, can have pre-existing condition exclusions of up to two years.

Maximums. A policy may have a maximum dollar amount that it will pay under the entire policy, a maximum it will pay within a given period of time or a limit on what it will pay for specific treatments. Hospital indemnity policies, for instance, may pay a specific amount per day, $40 for example, up to a maximum amount per month.

Renewal. Find out if and when a company can refuse to renew the policy. There are three common types of renewal conditions:

Guaranteed renewable. This means that the company agrees to renew each year until you reach a certain age or for life as long as you pay the premium.

You may see policies that are:

Conditionally renewable. This means that the company agrees to renew as long as the company continues to insure people in the state with the same kind of policy. If the company decides to discontinue selling that kind of policy here, the coverage can be non-renewed at the end of the policy year or the next premium due date.

Renewable at company option. A policy with this provision can be non-renewed for any reason at the end of the policy year. This kind of clause is prohibited in New Jersey for individual policies, but you may see sales materials for policies with this type of renewal clause from outside the state.

Outline of Coverage. Don't be pressured or frightened into buying something you may not ever be able to use, like a cancer policy. If the literature you have doesn't discuss the important items mentioned here, ask for an Outline of Coverage, which companies are required to supply.

A Few Cautions

Don't be fooled into thinking that a company or agent represents Medicare or any other federal or state sponsored insurance program. The N.J. Department of Insurance sets minimum standards for policies and companies, but it does not endorse or sell policies.

Be honest on the insurance application. If you lie or don't give a complete medical history, the company can refuse to pay. If someone else helps you fill out the application, check it before signing. It is your claim that will be denied if incorrect medical history is on the application.

Don't pay in cash. Use a check, money order or bank draft and be sure it is payable to the company, not the agent or anyone else. Remember, even a guaranteed renewable policy can be cancelled if you don't pay your premium, so you want a record of your payments.

By law, **depending on the type of insurance policy you are considering,** you **may** have a **10 to** 30-day "free-look" **period in which** to [read] **review** the policy and return it for a full refund if you are not satisfied. **(Medicare supplement and Long-term Care Policies have a 30-day free look period.)**

If you don't receive the policy within 30 days after applying, contact the company and obtain in writing a reason for the delay. If 60 days go by without information, call or write the Department of Insurance.

It is a violation of state regulations for your doctor to charge you a fee for filling out your claim form. If your doctor does charge you, you can file a complaint with the State Board of Medical Examiners, 28 W. State Street, Room 602, Trenton, NJ 08608.

Claim payments should be mailed promptly. So if you experience delays, don't be afraid to assert your rights. Insurance companies sometimes make mistakes; your inquiry or complaint may help to bring a faster or fairer claim settlement.

Getting Help

To get help filling out claim forms, evaluating policies and finding answers to your health insurance questions, you can contact the Senior Health Insurance Program (SHIP). SHIP is a free service designed to help you with your health insurance problems or questions. You can contact the New Jersey Division on Aging at 1-800-792-8820 for the number of the SHIP office in your county.

If you need other help, write the Department of Insurance, Enforcement and Consumer Protection, Senior Health Insurance Program, CN-325, Trenton, New Jersey 08625.

EXHIBIT B
MEDICARE DEDUCTIBLES AND CO-PAYMENTS FOR [1991] **1992**

Medicare Part A

Service	Length of Stay	You Pay	Medicare Pays
Hospitalization	First 60 days	[$628] **$652** deductible	Balance
	61st-90th day	[$157] **$163** co-payment per day	Balance
	91st-150th day	[$314] **$326** co-payment per day	Balance
	Beyond 150 days	All costs	Nothing
Post-hospital Skilled Nursing Facility Care	First 20 days	Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
	21st-100th day	[$78.50] **$81.50** co-payment per day	Balance
Home Health Care		Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
Hospice Care *Nursing care, physician's services, physical/occupational therapy, medical supplies, home health aide services, counseling services (except for bereavement counseling).		Nothing *provided all conditions are met (see Your Medicare Handbook)	All Costs
*Drugs and Biologicals		5% co-payment	Balance
*Respite Care		5% co-payment	Balance
Medicare Part B			
Medical Expenses		$100 annual deductible 20% of Medicare-approved amount after deductible	80% of Medicare-approved amount after deductible

EXHIBIT C
(COMPANY NAME)
NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE[—1991]

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In [1990] **(Current Calendar Year)** Medicare Pays Per Calendar Year	Effective January 1, [1991] **(Coming Calendar Year)** Medicare Will Pay	In [1990] **(Current Calendar Year)** Your Coverage Pays	Effective January 1, [1991] **(Coming Calendar Year)** Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	All but [$592] $_____ for first 60 days/ benefit period	All but [$628] $_____ for first 60 days/ benefit period		
Semi-Private Room & Board	All but [$148] $_____ a day for 61st-90th days/benefit period	All but [$157] $_____ a day for 61st-90th days/benefit period		

Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but [$296] $_____ a day for 91st-150th days (if individual) chooses to use 60 nonrenewable lifetime reserve days)	All but [$314] $_____ a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)
BLOOD	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period
SKILLED NURSING FACILITY CARE	[There is no prior confinement requirement for this benefit]	100% of costs of 1st 20 days (after a 3 day prior hospital confinement) benefit period
	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/benefit period	All but [$78.50] $_____ a day for 21st-100th days/benefit period
	All but $_____ a day for 21st-100th days/benefit period	
	Beyond 100 days—Nothing/benefit period	Beyond 100 days—Nothing/benefit period
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after [$75] $_____ deductible)	80% of allowable charges (after [$100] $_____ deductible/ calendar year)
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after [$75] $_____ deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after [$100] $_____ deductible/calendar year)
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after [$75]$_____ deductible/calendar year)	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in (after [$100] $_____ deductible/ calendar year)

(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)

(Describe any coverage provisions due to Medicare modifications.)

(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (Policy) CONTACT:

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)

EXHIBIT D
PART ONE—COVER PAGE(S)

(COMPANY NAME)
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE
BENEFIT PLAN(S): (insert letter(s) of plan(s) being offered)

Medicare supplement insurance may be sold in only ten (10) standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A". Some plans may not be available in your State.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).

Blood: First three (3) pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Extended Drugs ($3,000 Limit)
				Preventive Care					Preventive Care

PREMIUM INFORMATION (Boldface type)

We, (carriers name), may only raise your premium if we raise the premium for all policies like yours in this State. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

PART TWO—DISCLOSURE PAGE(S)

DISCLOSURES (Boldface type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY (Boldface type)

If you find that you are not satisfied with your policy, you may return it to (Carrier's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface type)

This policy may not fully cover all of your medical costs.
(for agents:)
Neither (Carrier's name) nor its agents are connected with Medicare.
(for direct response carriers:)
(Carrier's name) is not connected with Medicare.
This outline of coverage does not give all the details of Medicare. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The compay may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PART THREE—PLAN CHARTS

(Include for each plan prominently identified on the cover page, a chart illustrating the services, Medicare payments, plan payments and insured payment for each plan using the same language, in the same order uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. Include an explanation of any Innovative Benefits on the cover page and in the appropriate chart as specified below.)

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$0	$628 (Part A Deductible)
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	$0	Up to $78.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a nospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $100 (Part B Deductible) $0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	 $0 $0 $0	 Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	 Balance

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0 benefit of $50,000	 $0 80% to a lifetime maximum $50,000 lifetime maximum	 $250 20% and amounts over the

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	 All but $628 All but $157 a day All but $314 a day $0 $0	 $628 (Part A Deductible) $157 a day $314 a day 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	 All approved amounts All but $78.50 a day $0	 $0 Up to $78.50 a day $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	$0 $0 $0	Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	 All but $628 All but $157 a day All but $314 a day $0 $0	 $628 (Part A Deductible) $157 a day $314 a day 100% of Medicare Eligible Expenses $0	 $0 $0 $0 $0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	 All approved amounts All but $78.50 a day $0	 $0 Up to $78.50 a day $0	 $0 $0 All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $628	$628 (Part A Deductible)	$0
61st through 90th day	All but $157 a day	$157 a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $314 a day	$314 a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $78.50 a day	Up to $78.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES —Medically necessary skilled care services and medical supplies —Durable medical equipment First $100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $100 (Part B Deductible) $0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan —Benefit for each visit —Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) —Calendar year maximum	$0 $0 $0	Actual Charges to $40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week $1,600	Balance

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	$0 $0	$0 80% to a lifetime maximum benefit of $50,000	$250 20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE First $250 each calendar year Next $2,500 each calendar year Over $2,500 each calendar year	$0 $0 $0	$0 50%—$1,250 calendar year maximum benefit $0	$250 50% All Costs

PLAN J

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st through 90th day 91st day and after: —While using 60 lifetime reserve days —Once lifetime reserve days are used: —Additional 365 days —Beyond the Additional 365 days	All but $628 All but $157 a day All but $314 a day $0 $0	$628 (Part A Deductible) $157 a day $314 a day 100% of Medicare Eligible Expenses $0	$0 $0 $0 $0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st through 100th day 101st day and after	All approved amounts All but $78.50 a day $0	$0 Up to $78.50 a day $0	$0 $0 All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICARE CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

(INNOVATIVE BENEFIT)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
(Description of benefit) (Description of conditions, limitations, exclusions, including any applicable deductible and coinsurance requirements)	(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)	(Per day or per benefit period, as applicable)

EXHIBIT E

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT COVERAGE
(Carrier's Name and Address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement coverage and replace it with coverage issued by (Carrier's Name). Your new (policy) (certificate) (coverage) provides thirty (30) days within which you may decide without cost whether you desire to keep the coverage.

You should review this new coverage carefully. Compare it with all accident and sickness and other health coverage you may have. Terminate your present coverage only if, after due consideration, you find that purchase of this coverage is a wise decision.

STATEMENT TO APPLICANT BY CARRIER, AGENT (BROKER OR OTHER REPRESENTATIVE):

I (We) have reviewed your current medical or health coverage. The replacement involved in this transaction does not duplicate coverage, to the best of my (our) knowledge. The replacement policy is being purchased for the following reason(s) (check one):

☐ Additional benefits
☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums
☐ Other (please specify):

(1) Health conditions which you presently may have (preexisting conditions) may not be immediately or fully covered under the new (policy) (certificate) (coverage). This could result in denial or delay of a claim for benefits under the new (policy) (certificate) (coverage) whereas a similar claim may be payable under your present coverage.

(2) State law provides that your replacement (policy) (certificate) (coverage) may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods in the new (policy) (certificate) (coverage) for similar benefits to the extent such time had Partially or fully expired under the original policy.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to answer truthfully and completely all questions on the application concerning your medical and health history. Failure to include all material medical information on the application may provide a basis for (Carrier's Name) to deny any future claims and to refund your payments as though your (policy) (certificate) (coverage) had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

_____
Signature of Agent, Broker or Other Representative
(Direct response carriers may omit this signature line.)

_____
Typed Name and Address of Agent, Broker or Other Representative
(Direct response carriers may omit this signature line.)

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's signature

_____
Carrier's Name

EXHIBIT F

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code ___ ____

Person Completing This Exhibit _____

Title _____ Telephone Number (___) _____

Line		(a) Earned Premium (x)	(b) Incurred Claims (y)
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current Year's issues (z)		
	c. Net (for reporting purpose = 1a - 1b)		
2.	Past Year's Experience (All Policy Years)		
3.	Total Experience (Net Current Year + Past Years' Experience)		
4.	Refunds last year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8.	Experienced Ratio Since Inception: Total Actual Incurred Claim (line 3, col. b) / Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) = Ratio 2		
9.	Life Years Exposed Since Inception _____		

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10. Tolerance Permitted (obtained from credibility table) _____

11. Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than benchmark ratio, then proceed.

12. Adjusted Incurred Claims =

(Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6)) × Ratio 3 (line 11)

13. Refund = Total Earned Premiums (line 3, col. a)—Refunds Since Inception (line 6)) - (Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1))

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000+	0.0%
5,000–9,000	5.0%
2,500–4,999	7.5%
1,000–2,499	10.0%
500–999	15.0%

If less than 500, no credibility.

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan

(x) Includes model loadings and fees charged.

(y) Excludes Active Life Reserves

(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name—Please Type

Title

Date

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year _____

TYPE _____ SMSBP (p) _____

FOR THE STATE OF _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number (___) ____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) Policy Year Loss ratio
1		2.770		0.442		0.000		0.000		0.4
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception = (l + n) / (k + m)

(a): Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)

(b): For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

(p): "SMSBP" means Standardized Medicare Supplement Benefit Plan.

Reporting Form for the Calculation of Benchmark Ratio Since Inception for Individual Policies for Calendar Year _____

TYPE _____ SMSBP (p) _____

FOR THE STATE OF _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____

Person Completing This Exhibit _____

Title _____ Telephone Number (__) _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b)x(c)	(e) Cumulative Loss ratio	(f) (d)x(e)	(g) Factor	(h) (b)x(g)	(i) Cumulative Loss ratio	(j) (h)x(i)	(o) Policy Year Loss ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception = (l + n) / (k + m)

(a): Year 1 is the current calendar year minus 1; Year 2 is the current calendar year minus 2; ... etc. ... (Example: If current year is 1991, then Year 1 is 1990; Year 2 is 1989; etc.)

(b): For calendar year(s) in column (a), the premium earned during each year for policies issued in each specific year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios, but are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

(p): "SMSBP" means Standardized Medicare Supplement Benefit Plan.

EXHIBIT G

FORM FOR REPORTING MULTIPLE MEDICARE SUPPLEMENT POLICIES

Company Name _____

Address: _____

_____

Phone Number: (_____) _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (please type)

Date

LAW AND PUBLIC SAFETY

(a)

BOARD OF MEDICAL EXAMINERS

Preparation of Patient Records

Proposed Amendment: N.J.A.C. 13:35-6.5

Authorized By: Board of Medical Examiners, Sanford Lewis, M.D., President.

Authority: N.J.S.A. 45:9-2; P.L. 1991, c.201.

Proposal Number: 1992-20.

Submit written comments by February 5, 1992 to:

Charles A. Janousek, Executive Director
State Board of Medical Examiners
28 West State Street—Room 602
Trenton, New Jersey 08608

If warranted by comments submitted, the Board may schedule a public hearing on any or all aspects of the rules. Persons interested in making a presentation at such hearing should notify the Board at the time of submitting written material prior to the date set forth above. Notice shall be provided, including to all such persons, if a public hearing is scheduled.

The agency proposal follows:

Summary

The proposed rule amendment clarifies that treatment records must include the licensee's recommended follow-up for each patient. Where communication of significant test results to the patient is necessary for proper medical care, the record must document if attempts to reach the patient were unsuccessful. The amendment also specifies that any corrections or additions made to an existing record must be so identified. The record must document the existence of any advance directive for health care given by the patient. In addition, the amendment specifies the manner in which patient records must be kept, if maintained by computer as an alternative to traditional handwritten or typed records.

Social Impact

The proposed amendment clarifying mandatory minimum content of a patient record should benefit the licensee who must regularly re-evaluate the progress of a patient under care. It will promote care in assuring that when a licensee has deemed it important to order diagnostic tests, the patient will be timely informed of results where action needs to be taken. It will also benefit a patient whose status must be reviewed by a subsequent treating licensee. It will aid the Board in assessing the quality of a licensee's professional services to the patient by demonstrating the professional judgment integrating examination, testing, diagnosis, treatment and progress.

The requirement to document the existence of a patient's advance directive for health care is pursuant to the New Jersey Advance Directives for Health Care Act, P.L. 1991, c.201, Sec. 10.

The proposed amendment regarding computers is in response to inquiries from practitioners, from the Department of Health, and from the Radiological Society of New Jersey regarding permissibility of record preparation in a contemporary form which is legible and encourages more detail regarding the patient interaction. The present Board rule requires preparation of contemporaneous, permanent records, and requires that "originals" be provided for examination in certain circumstances. These requirements must be re-interpreted if computerized records are permitted, in part because of the potential for fraudulent or accidental alteration of a record subsequent to an untoward event.

Amendment of the current rule to accommodate computer use is desirable for patient records prepared by Board licensees practicing in any location. Special problems arise is some areas of practice, such as interpretation of radiological studies. Such studies, especially for a hospitalized patient, are typically dictated and then transcribed at a later date when the reading radiologist may not be immediately available. Hospital (as with office records) generally require an original handwritten signature to authenticate the licensee's entry. Two rules of the State Department of Health have some bearing on these matters: N.J.A.C. 8:43G-28.10(b) requires that all radiologic tests be interpreted, on a preliminary basis, within 24 hours of the time the test results are available for interpretation. N.J.A.C. 8:43G-15.2(a)3 requires that hospitals have procedures for the protection of medical record information against loss, tampering, alteration, destruction or unauthorized use; subsection (b) of the same rule requires that all entries in the patient's medical record shall be written legibly in ink, dated and signed by the recording person or, if a computerized medical records system is used, authenticated. However, no specific definition for the term "authenticated" is provided. The Radiological Society has informed the Board that in at least one hospital, the Radiology Department authenticates its records by means of a software program providing a confidential personal code for each radiologist-user and a mechanism for defining reports as "preliminary" or "final." This method appears to the Board to satisfy the intent of the Board's patient record rule, and should be equally applicable to general office records of all Board licensees, if the rule is amended to recognize authenticated electronic signatures. The Board has therefore proposed this rule amendment in an attempt to accommodate the various interests involved, weighting the balance in favor of confirmed accuracy of the patient record and reduction of the potential for fraudulent or accidental alteration of a computerized record.

Economic Impact

The rule amendment clarifying record content will have no economic impact, as the cited material should already be prepared by all Board licensees. The amendment allowing computerization will have an economic impact solely on the licensee who elects to use computerized records rather than traditional written or typed records. The impact will vary depending on the type of medical records maintained, the nature and extent of the computerization and the type of software selected by the licensee. Therefore, the cost to a licensee of the program selected cannot be predicted in this rule. The Board believes that many of its licensees will wish to utilize the modern mode of record-preparation

because of its many conveniences; those licensees who do make the transition must recognize the need for preservation of the record against accidental destruction and for integrity of its contents, and must pay the reasonable cost to accommodate those factors. For Board licensees practicing in a hospital setting, no change is contemplated providing that the institution is already complying with Department of Health rules on the subject.

There may be an economic impact resulting from physician awareness of the patient's wishes regarding medical care in certain circumstances as reflected in an advance directive. This recognition of patient autonomy may on occasion result in avoidance by the patient of very costly medical treatment in situations where the patient did not want such treatment but was formerly unable to express those wishes in an enforceable way.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., licensees of the Board of Medical Examiners are deemed "small businesses" within the meaning of the statute, the following statement is applicable.

The proposed rule amendment will apply to all of the approximately 32,500 current licensees of the Board, including physicians and surgeons, podiatrists, bioanalytical laboratory directors, certified nurse midwives, acupuncturists, athletic trainers, and hearing aid dispensers. Compliance with the rule amendment involves no reporting or recordkeeping requirements other than those already expected of licensees. It does not require the retention of professional services except to the extent the licensee elects to computerize patient records and, in that case, would involve initial capital costs of the computer equipment and upkeep. Since the intent of the rule amendment is to assure uniformity of minimum record content and safety and integrity of a computerized patient record, the rule amendments must be applied to all licensees without differentiation as to type of licensee or size of practice.

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

13:35-6.5 Preparation of patient records, **computerized records,** access to or release of information; confidentiality, transfer or disposal of records

(a) (No change.)

(b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1. To the extent applicable, professional treatment records shall reflect:

Recodify existing 1.-7. as **i.-vii.** (No change in text.)

[8.]**viii.** Treatment ordered, including specific dosages, quantities and strengths of medications **including refills** if prescribed, administered or dispensed, **and recommended follow-up**; [and]

[9.]**ix.** The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices[.];

x. Documentation when, in the reasonable exercise of the physician's judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and

xi. Documentation of the existence of any advance directive for health care, and associated pertinent information.

2. Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialled by the licensee.

3. A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:

i. The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;

ii. An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry, and full printed name of the treatment provider. The physician shall finalize or "sign" the entry by means of a confidential personal code ("CPC") and include date of the "signing";

iii. Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as "preliminary" until reviewed, finalized and dated by the responsible physician as provided in (b)3ii above;

iv. The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;

v. The system shall be designed in such manner that, after "signing" by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;

vi. Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner; and

vii. A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:

(1) To a physician responsible for the patient's care;

(2) To a representative of the Board of Medical Examiners, the Attorney General or the Division of Consumer Affairs as soon as practicable and no later than 10 days after notice; and

(3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency).

(c)-(h) (No change.)

(a)

STATE BOARD OF PROFESSIONAL ENGINEERS AND LAND SURVEYORS

Land Surveyors Corner Markers

Proposed Amendment: N.J.A.C. 13:40-5.1

Authorized By: State Board of Professional Engineers and Land Surveyors, John DeGrace, President.

Authority: N.J.S.A. 45:8-27 et seq.; 45:8-28(e); 45:8-58(c) and 45:1-21(h).

Proposal Number: PRN 1992-2.

Submit written comments by February 5, 1992 to:

Arthur Russo, Executive Director
State Board of Professional
Engineers and Land Surveyors
124 Halsey Street, 6th Floor
P.O. Box 45015
Newark, New Jersey 07101

The agency proposal follows:

Summary

Effective January 19, 1988, N.J.A.C. 13:40-5.1(d) was amended to limit the ability to contractually agree to omit corner markers to the "ultimate user," defined as the purchaser of the property or the attorney representing the purchaser. At that time, the State Board of Professional Engineers and Land Surveyors found a number of instances where a home purchaser expected to have corners set but this was not done because the surveyor and some other interested party had agreed to omit them. Since that amendment was adopted, the Board has received numerous complaints from purchasers alleging that their attorneys have, without their knowledge, waived the corner setting requirements. In many instances, the subsequent setting of corner markers revealed the existence of a buried corner.

On December 4, 1989, in response to the Board's experience as stated above, a proposed amendment to the rule was published at 21 N.J.R. 3715(a). That amendment would have required the setting of corner markers in all instances by deleting language which permitted the "ultimate user" by "written contractual agreement" to specify otherwise. Following the receipt of public comments and further review of both the proposed amendment and the existing regulation, the Board has decided to repropose amendments.

The current proposed amendment would continue the basic requirement that corner markers be set in all surveys unless the surveyor obtains a written waiver signed by the "ultimate user" of the property. The ultimate user of the property is re-defined to mean only the purchasers of property in order to assure that only such individuals exercise the right to waive corner marker settings. The amendment sets forth a form waiver which may be used by licensees as well as a required disclosure to be set forth on plans or surveys to indicate when a waiver of corner markings has been obtained by the surveyor. Where a waiver is obtained the licensee is required to retain it for a six year period.

Social Impact

It is contemplated that the continued requirement to set corner markers with the new provision to obtain a written waiver directly and exclusively from the purchaser of the property will enhance the quality, accuracy and continuity of surveys and provide additional important information and involvement to real property purchasers. Initially, it should be noted that the continued requirement to set corner markers discourages the unscrupulous practice of a survey being prepared solely from pre-existing documents rather than an independent taking of "fresh" measurements and citings.

In requiring signed waivers containing a disclosure of the purchaser's right to corner marker settings, the amendment assures that purchasers exercising their right to waive corner marker settings are aware of their right to this service, and where the option to forego the same is exercised, a written record of the waiver is retained along with a noted public disclosure thereof on the plat or plan of the survey. Further, licensees are put on clear notice of the regulatory standards applicable to the continued requirements to set corner markers and the requirements for obtaining waivers.

Economic Policy

No foreseeable adverse economic impact is created by the proposed amendment. The economic impact on the public of the continued requirement to set corner markers remains the same. In those instances where a waiver is obtained, disclosure of the right to waive the service will have been made, and the cost thereof will be avoided by the purchaser. It is also contemplated that by requiring licensees to obtain waivers where corner markers are not to be set, the parties to the survey will be placed in a position whereby the material aspects of the survey will be discussed in advance of the work being performed, thus avoiding disputes and misunderstandings.

Regulatory Flexibility Analysis

In accordance with the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., it has been determined that, with few exceptions, most land surveying entities are small businesses that will be affected by the proposed amendment. The specific number is impossible to determine at present. However, the proposed compliance requirements are equally applicable to all land surveying licensees and entities without differentiation as to types and sizes of businesses. Any such differentiation would destroy the value of the rule.

The proposed amendment entails no additional reporting and limited recordkeeping requirements for small businesses. No professional services are needed for compliance. The amendment requires no initial capital costs. The annual cost of compliance is a few dollars per corner for the Board-required material and corner cap, and this expense will decrease as additional corners are set. Because the required material is inexpensive, the economic impact of the proposed amendment on small businesses is minimized. The economic impact on the public will continue to be in the form of increased survey fees for which an increased service (corner markers) will be received to aid in defining property boundaries thus reducing property line disputes and improving the quality of surveys.

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

13:40-5.1 Land surveyors; preparation of land surveys

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

(d) Appropriate corner markers, such as stakes, iron pipes, cut crosses, monuments, and [so forth] **such other markers as may be authorized by (d)2 below,** shall be set either by the licensed land surveyor or under the supervision of the licensed land surveyor. Such markers shall be set at each property corner not previously marked by a property marker, unless the actual corner is not accessible, or unless [written contractual agreements with] **a written waiver signed by** the ultimate user [specify otherwise] **is obtained and retained for a period of six years by the surveyor performing the survey. A waiver obtained from a purchaser pursuant to this subsection shall be in the following format, or its substantial equivalent:**

WAIVER AND DIRECTION NOT TO SET CORNER MARKERS

TO: _____

(Name, address and telephone number of Land Surveyor)

FROM: _____

(Name, address and telephone number of Purchaser)

Re: _____

Property (Lot & Block number, municipality or other identifier)

This is to advise that I/we have been made aware of my/our right to have corner markers set as part of a survey to be performed on property which is being purchased by me/us. That right is hereby waived and you are directed to perform the land survey without the setting of corner markers as provided by the regulation of the New Jersey Board of Professional Engineers and Land Surveyors.

_____

Purchaser(s)

Dated: _____

For the purpose of this section "ultimate user" shall mean, in the case of a transfer of title, the purchaser of the property [or the attorney representing that purchaser and not a representative agent such as a title company, real estate agent, real estate broker, mortgage company or other individual or entity]. When [written contractual arrangements are made] **a waiver is obtained** to omit corner markers, a specific notation stating that such omissions have been made [by written contractual agreement with] **by direction of** the ultimate user shall be clearly displayed on the plat or plan of survey[.] **by the following notation or its equivalent:**

Waiver of setting corner markers obtained from ultimate user pursuant to the Board of Professional Engineers and Land Surveyors regulation, N.J.A.C. 13:40-5.1(d).

This notation must relate specifically to that plat or plan of survey and may not be included as a preprinted title block, standard form, or other reproducible medium.

1.-5. (No change.)

(e)-(n) (No change.)

(a)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF RESPIRATORY CARE

Fees

Proposed New Rule: N.J.A.C. 13:44F-8.1

Authorized By: Emma Byrne, Director, Division of Consumer Affairs.

Authority: N.J.S.A. 45:14E-7(f) and (g).

Proposal Number: PRN 1992-21.

Submit written comments by February 5, 1992 to:
Marianne Kehoe, Executive Director
State Board of Respiratory Care
Post Office Box 45031
Newark, New Jersey 07101

The agency proposal follows:

Summary

The Respiratory Care Practitioner Licensing Act, P.L. 1991, c.31, established the State Board of Respiratory Care in the Division of Consumer Affairs. The Act became effective on August 20, 1991. The new Board of Respiratory Care must establish a fee schedule in accordance with N.J.S.A. 45:14E-7 in order to cover the licensing, investigative and program costs associated with the administration of the Board.

Accordingly, the Board is proposing a new rule, to be codified at N.J.A.C. 13:44F-8.1, which sets forth its initial fee schedule. Included in the fee schedule are the application fee, initial and renewal license fees, late renewal fee, duplicate license fee, temporary license fees, reinstatement fee, duplicate wall certificate fee and verification of licensure fee.

Social Impact

The proposed fee schedule, which will affect all potential licensees of the Board of Respiratory Care, is necessary to enable the Board to discharge its statutory obligations, which include the evaluation of applicants for licensure and the regulation of the practice of respiratory care. The new fee schedule will provide the Board with the minimum financial resources necessary to carry on its responsibilities to protect the public health, safety and welfare by ensuring professional competence and the maintenance of high professional standards.

Economic Impact

The proposed fee schedule should yield revenues sufficient to cover the expenses generated by the Board's many statutory obligations: evaluation of applicants for licensure; issuance of licenses; investigation of complaints; initiation and prosecution of disciplinary actions; and addressing issues relevant to the practice of respiratory care. The proposed fee schedule will have a direct economic impact on Board licensees in that they will be required to pay licensing fees. However, pursuant to N.J.S.A. 45:1-3.2, the Board is required to be self-funding; that is, administrative costs must be met through penalties and licensing fees. As required by the statute, the fees have been calculated not to exceed the amount necessary to fund the Board's administration. No direct economic impact upon the consumer is expected.

Regulatory Flexibility Analysis

If, for the purposes of the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., respiratory care practitioners are deemed "small businesses" within the meaning of the statute, the following statements are applicable.

The Board anticipates that approximately 2,400 individuals will seek licensure as respiratory care practitioners. The proposed rule does not involve any reporting or recordkeeping nor does it necessitate the retention of professional services for compliance. The only compliance requirement is completing the licensure application and paying the appropriate licensing fees in a timely manner. Since the fees have been set at the lowest amount that will cover the Board's operating expenses, the intent of the Regulatory Flexibility Act to minimize adverse economic impact has been implemented.

Full text of the proposed new rule follows:

CHAPTER 44F
STATE BOARD OF RERSPIRATORY CARE

SUBCHAPTERS 1.-7. (RESERVED)

SUBCHAPTER 8. FEES

13:44F-8.1 Fees

(a) State Board of Respiratory Care charges for licensure and other services are as follows:

1. Application fee	$125.00
2. Initial license fee	
i. During the first year of a biennial renewal period	180.00
ii. During the second year of a biennial renewal period	90.00
3. License renewal fee, biennial	180.00
4. Late renewal fee (within 30 days)	100.00
5. Duplicate license fee	75.00
6. Six-month temporary license	45.00
i. Temporary license renewal	45.00
7. Eighteen-month temporary license	135.00
8. Temporary visiting license	90.00
i. Temporary visiting license renewal	90.00
9. Reinstatement fee (after 60 days)	175.00
10. Duplicate wall certificate	50.00
11. Verification of licensure	50.00

(a)

DIVISION OF CONSUMER AFFAIRS

Automotive Dispute Resolution

Proposed Amendments: N.J.A.C. 13:45A-26.1, 26.2, 26.4 and 26.14

Authorized By: Emma Byrne, Director, Division of Consumer Affairs.

Authority: N.J.S.A. 56:12-49 and P.L. 1991, c.130.

Proposal Number: PRN 1992-3.

Submit written comments by February 5, 1992 to:
Emma Byrne, Director
Division of Consumer Affairs
Post Office Box 45027
Newark, New Jersey 07101

The agency proposal follows:

Summary

Pursuant to P.L. 1991, c.130 ("the Act"), the definition of "motor vehicle" under the Lemon Law (N.J.S.A. 56:12-29 et seq.) was amended effective August 4, 1991 to include motor vehicles purchased or leased in New Jersey. Previously, the Lemon Law applied only to motor vehicles registered in New Jersey. The intent of the statutory amendment was to extend Lemon Law consumer protections to New Jersey residents who purchase or lease a motor vehicle in this State and subsequently move out of State and to permit out-of-State residents who purchase or lease a motor vehicle in New Jersey to proceed under the Lemon Law.

The Division of Consumer Affairs is proposing to amend its automotive dispute resolution rules, N.J.A.C. 13:45A-26, to conform them to the requirements of the Act. The proposed amendments provide that a motor vehicle purchased or leased in this State is covered under the Lemon Law without regard to where the vehicle is registered. Also proposed is an amendment to furnish the Division's current address.

Social Impact

The proposed amendments implement legislation which extends New Jersey's Lemon Law protections to out-of-State residents who purchase or lease a defective vehicle in New Jersey. These protections will be especially beneficial to purchasers or lessees who register their defective vehicles in states which do not have a Lemon Law (currently five states do not) or which have Lemon Laws that are not as effective as New Jersey's. Pursuant to the provisions of P.L. 1991, c.130 and these amendments, these individuals will be assured of active and immediate aid by New Jersey government agencies in the event they purchase or lease a "lemon" in New Jersey—a passenger automobile or motorcycle with substantial defects that continue to exist after multiple repair attempts.

Economic Impact

The proposed amendments impose no economic impact on any individual or entity other than that imposed pursuant to P.L. 1991, c.130, which became effective on August 4, 1991. Under the provisions of that Act, an out-of-State resident who purchases or leases a vehicle in New Jersey now has the option of proceeding under New Jersey's laws rather than the laws of his or her home state. An out-of-State resident who purchases a "lemon" in New Jersey may benefit economically in a New Jersey proceeding either because his or her home state does not have a Lemon Law or because the home state's Lemon Law is not as effective as New Jersey's. These individuals can be reimbursed for their investment in the faulty vehicle as well as for other costs incurred, including the $50.00 application fee.

The statutory extension of New Jersey's Lemon Law benefits to out-of-State purchasers or lessees may result in additional expenses to automobile manufacturers in instances where an aggrieved consumer from a state which does not require manufacturer liability for the consumer's legal fees chooses to proceed and prevails in New Jersey. The Division stresses that the proposed amendments are required by P.L. 1991, c.130 and that it has no choice but to amend its automotive dispute resolution rules to conform to the statute.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required with regard to the impact of the proposed amendments on automobile manufacturers who produce motor vehicles that are sold or leased in New Jersey, since none of these manufacturers employ fewer than 100 employees.

Many automobile dealers do qualify as small businesses under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., and the following analysis applies to them: The only compliance requirement imposed upon automobile dealers under these amended rules is the requirement that they provide to the consumer documentation of repair attempts. The proposed amendments will create no additional compliance requirements for automobile dealers since documentation of repair attempts is a record that would be maintained in the ordinary course of business. In any event, because the record of repair attempts is essential to the Division's dispute resolution system, it is not feasible to exempt small businesses from the requirement to assist in the process by supplying the record upon request.

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

13:45A-26.1 Purpose and scope

(a) (No change.)

(b) This subchapter is applicable to:

1. All manufacturers of passenger cars and motorcycles registered, **sold or leased** in the State of New Jersey;

2. All purchasers and lessees of passenger cars and motorcycles registered, **sold or leased** in the State of New Jersey; and

3. (No change.)

13:45A-26.2 Definitions

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

...

"Motor vehicle" means a passenger automobile or motorcycle as defined in N.J.S.A. 39:1-1, that is registered, **sold or leased** in the State of New Jersey, whether purchased, leased, or repaired in the State or outside the State.

...

13:45A-26.4 Lemon Law Unit

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

(c) All correspondence by consumers or manufacturers to the Division of Consumer Affairs regarding Lemon Law matters shall be directed to the attention of the Lemon Law [unit] **Unit**, as follows:

Division of Consumer Affairs
Lemon Law Unit
[1100 Raymond Boulevard] **Post Office Box 45026**
Newark, New Jersey [07102] **07101**
Tel. No. (201) 648-3135

13:45A-26.14 Manufacturer's informal dispute resolution procedures

(a) The LLU shall compile a roster of American and foreign manufacturers of passenger automobiles and motorcycles registered, **sold or leased** in New Jersey.

(b)-(d) (No change.)

(a)

VIOLENT CRIMES COMPENSATION BOARD

Eligibility of Claims

Proposed Amendment: N.J.A.C. 13:75-1.6

Authorized By: Violent Crimes Compensation Board, Jacob C. Toporek, Chairman.

Authority: N.J.S.A. 52:4B-9.

Proposal Number: PRN 1992-10.

Submit comments by February 5, 1992 to:
Cindy R. Merker, Esq.
Violent Crimes Compensation Board
60 Park Place
Newark, New Jersey 07102

The agency proposal follows:

Summary

As a result of the proposed amendment, being injured while participating in an illegal activity is no longer an absolute bar for eligibility of compensation. Participating in an illegal activity is a factor the Board will consider in determining if full, partial or no compensation should be awarded to a victim or claimant.

Social Impact

The proposed amendment allows the Board to consider claim applications for compensation which previously were absolutely barred. Therefore, more victims and claimants may be eligible for some compensation. The amendment also puts victims and claimants on notice of the Board's decision to use more discretion in considering claims where the victim was injured while participating in an illegal activity.

Economic Impact

The proposed amendment will allow the Board to pay certain victims and claimants who previously were ineligible for compensation. Therefore, claim funds will be effected by this change.

Regulatory Flexibility Statement

The Violent Crimes Compensation Board's rules govern the process by which victims of violent crimes and their attorneys may make claims for compensation.

The proposed amendments impose no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., since they establish compensation eligibility criteria for individual victims. Therefore, a regulatory flexibility analysis is not required.

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

13:75-1.6 Eligibility of claims

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

(c) Any claimant who is held **by the Board** to be responsible for the crime upon which a claim is based, or is held to have been an accomplice or conspirator of the offender [or is injured while participating in an illegal activity] is not eligible for compensation. For incidents occurring after March 3, 1983 and continuing through March 4, 1991, a relative of the offender or a victim living with the offender as a member of the offender's family relationship group may recover; if subsequent to the incident giving rise to the claim, the claimant no longer resides in the same household as the offender and the claimant cooperated in the prosecution of the offender.

1. (No change.)

(d) The Board reserves the right to consider any circumstances it deems to be relevant, including, but not limited to, provocation, consent, **participation in an illegal activity** or behavior on the part of the victim which directly, or indirectly, contributed to his **or her** injury or death, the prior case history of the victim which may also include matters pertaining to the victim's medical history, and whether the victim cooperated with reasonable requests of law enforcement authorities or showed a compelling health or safety reason why they could not cooperate.

(e)-(f) (No change.)

(b)

VIOLENT CRIMES COMPENSATION BOARD

Compensable Damages

Reimbursement for Loss of Earnings

Proposed Amendment: N.J.A.C. 13:75-1.7

Authorized By: Violent Crimes Compensation Board, Jacob C. Toporek, Chairman.

Authority: N.J.S.A. 52:4B-9.

Proposal Number: PRN 1992-11.

Submit comments by February 5, 1992 to:
Cindy R. Merker, Esq.
Violent Crimes Compensation Board
60 Park Place
Newark, New Jersey 07102

The agency proposal follows:

Summary

As a result of the proposed amendment, the Board's maximum reimbursement for loss of earnings for claims filed as of January 1, 1992

shall not exceed a total of 52 weeks and for loss of support a total of 36 months.

Social Impact

The proposed amendment will allow the Board to retain and reserve funds so that it can compensate a greater number of victims and also put all victims and claimants on notice that the Board will limit the amount of loss of earnings and loss of support paid on claims filed as the effective date of this amendment.

Economic Impact

Since money used to compensate victims and claimants is continually evaporating due to cutbacks in funding, increased medical costs and an ever increasing number of applications, the Board is taking measures to limit payments for loss of earnings and loss of support. The Board is taking these measures based on its statute which states that it must take into account the availability of funds appropriated to the Board in determining amounts of compensation.

Regulatory Flexibility Statement

The Violent Crimes Compensation Board's rules govern the process by which victims of violent crimes and their attorneys may make claims for compensation.

The proposed amendment imposes no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:4B-16 et seq., since they establish a compensation eligibility criteria for individual victims. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposed amendment follows (additions indicated in boldface **thus**):

13:75-1.7 Compensable damages

(a) (No change.)

(b) The Board may order the payment of compensation for expenses incurred as a result of the personal injury or death of the victim. These expenses must represent a pecuniary loss to the claimant as defined by N.J.S.A. 52:4B-1 et seq. and these rules consisting of, but not limited to, work and earnings loss, dependents' loss of support, other reasonable pecuniary loss incurred by claimant due to victim's death. The Board may also award payment for such allowable expenses which the Board determines to be reimbursable within these rules, such as reasonable charges for reasonably needed products and services, medical care, rehabilitation, rehabilitative occupational training, and other remedial treatment and care.

1. The Board may order the payment of compensation for the loss of earning power as a result of the total or partial incapacity of the victim. Said loss includes work loss or loss of income the injured person would have performed if he had not been injured, and expenses reasonably incurred by him in obtaining services in lieu of those he **or she** would have performed for income. In computing the earnings loss, the Board may consider any income received from substitute work actually performed by the claimant or any income that would have been earned through available appropriate substitute work he **or she** was capable of performing but unreasonably failed to undertake, and reduce the award, accordingly.

2. In computing the earnings loss of the victim/claimant or in the case of death, the loss of support of the claimant/dependent, the Board shall only consider the victim's earnings and/or the amount of money the decedent was contributing to the household at the time of the injury or death of the victim. Where the dependents of a decedent have received or are receiving a greater sum of money from other sources by reason of the decedent's death than the sum contributed to their support by the decedent at the time of death, no compensation for loss of support shall be awarded to the dependents. The Board, however, reserves the right to review its determination should the claimant's dependency, marital or earnings status be altered, and to modify its award accordingly.

i. Notwithstanding the date of the incident, for any application filed as of the effective date of this amendment, the maximum reimbursement for loss of earnings shall not exceed a total of 52 weeks and for loss of support a total of 36 months.

(c)-(j) (No change.)

(a)

VIOLENT CRIMES COMPENSATION BOARD

Procedure to Request Board Action to Promulgate, Amend or Repeal Rules

Proposed New Rule: N.J.A.C. 13:75-1.29

Authorized By: Violent Crimes Compensation Board, Jacob C. Toporek, Chairman.

Authority: N.J.S.A. 52:4B-9.

Proposal Number: PRN 1992-12.

Submit comments by February 5, 1992 to:
Cindy R. Merker, Esq.
Violent Crimes Compensation Board
60 Park Place
Newark, New Jersey 07102

The agency proposal follows:

Summary

With the proposed new rule, the Board has established a procedure for persons requesting the Board to promulgate, amend or repeal its rules contained in the Administrative Code.

Social Impact

The proposed new rule will put the general public on notice that in order to request the Board to promulgate, amend or repeal its rules contained in the Administrative Code, they must comply with N.J.S.A. 52:14B-4(f).

Economic Impact

The proposed new rule will have no economic impact on the Board or victims and claimants seeking compensation since it is procedural in nature.

Regulatory Flexibility Statement

The Violent Crimes Compensation Board's rules govern the process by which victims of violent crimes and their attorneys may make claims for compensation.

The proposed new rule imposes no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A 52:46-16 et seq., since they establish compensation eligibility criteria for individual victims. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposed new rule follows:

13:75-1.29 Procedure to request Board action to promulgate, amend or repeal rules

(a) Persons requesting Board action to promulgate, amend or repeal rules shall comply with P.L. 1981, c.27, §11 (N.J.S.A. 52:24B-4(f)) and any amendments thereto and any implementing rules as adopted by the Office of Administrative Law.

(b) Such persons may obtain forms for petitioning this Board's Administrative Code rules from the Violent Crimes Compensation Board.

(c) When considering the petition, the Board shall comply with time lines and procedures contained in P.L. 1981, c.27, §11 (N.J.S.A. 52:14B-4(f)).

(b)

VIOLENT CRIMES COMPENSATION BOARD

Determinations, Presumptions and Burdens of Proof

Proposed New Rule: N.J.A.C. 13:75-1.30

Authorized By: Violent Crimes Compensation Board, Jacob C. Toporek, Chairman.

Authority: N.J.S.A. 52:4B-9.

Proposal Number: PRN 1992-13.

Submit comments by February 5, 1992 to:
Cindy R. Merker, Esq.
Violent Crimes Compensation Board
60 Park Place
Newark, New Jersey 07102

The agency proposal follows:

Summary

As a result of the proposed new rule, the Board is establishing the type of burden of proof necessary for an applicant to overcome in proving the eligibility of their claim. The Board is also stating that certain facts are taken into consideration when determining the eligibility of a claim application but the ultimate decision is within the discretion of the Board.

Social Impact

The proposed new rule will put all victims and claimants on notice that they have the burden of proof as to the eligibility of their claim and the burden is met by a preponderance of the credible evidence. Victims and claimants will also be put on notice that the Board can take into consideration conclusions of law enforcement agencies and dispositions of criminal proceedings, but the ultimate determination made on a claim application is the obligation of the Board.

Economic Impact

The proposed new rule will have no economic impact on the Board or the victims and claimants applying for compensation since it is procedural in nature.

Regulatory Flexibility Statement

The Violent Crimes Compensation Board's rules govern the process by which victims of violent crimes and their attorneys, may make claims for compensation.

The proposed new rule imposes no reporting, recordkeeping or other compliance requirements upon small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:4B-16 et seq., since they establish compensation eligibility criteria for individual victims. Therefore, a regulatory flexibility analysis is not required.

Full text of the proposed new rule follows:

13:75-1.30 Determinations, presumptions and burdens of proof

(a) Applicants filing petitions for compensation have the burden of proof as to eligibility of the claim filed and as to all its elements and items of compensation. This burden of proof is met by a preponderance of the credible evidence.

(b) The Board may give substantial weight to conclusions of investigative law enforcement agencies and dispositions of criminal proceedings including, but not limited to, pleas of guilt and jury verdicts, but considered along with all other evidence, the ultimate determination made on a claim application is the obligation of the Board uncontrolled by determinations of others.

OTHER AGENCIES

(a)

CASINO CONTROL COMMISSION

Internal Controls

Personnel Assigned to the Operation and Conduct of Gaming and Slot Machines

Proposed Amendment: N.J.A.C. 19:45-1.12

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-70(f) and 70(j).

Proposal Number: PRN 1992-25.

Submit comments by February 5, 1992 to:
Mary S. LaMantia, Assistant Counsel
Casino Control Commission
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

The proposed amendments to N.J.A.C 19:45-1.12 revise the staffing requirements for the operation and supervision of table games by all licensed casinos. The modified standards acknowledge the casino industry's need for some degree of flexibility in assigning supervisory staff in response to a multitude of varying circumstances, particularly with the advent of 24-hour gaming in Atlantic City.

Revised standard staffing levels are outlined in new subsection (c). The amended rules would, among other things, permit a pit boss to supervise a maximum of 16 gaming tables, eliminating any differentiation between the level of supervision required for a craps game and any other game. The amendment would also increase the number of minibaccarat tables which may be supervised by one floorperson, from two to four tables. The new standards further clarify that a casino clerk may supervise up to 24 gaming tables.

In addition to these incrases in standard staffing, the proposed amendments establish procedures for the implementation of revised supervision levels. A casino licensee would be permitted to utilize one floorperson to supervise up to six blackjack, roulette, minibaccarat, sic bo, red dog or big six games, in any combination, and may utilize a single pit boss to supervise up to 24 table games, provided that the casino manager or shift manager provides at least 24 hours notice to the Commission's principal inspector. The proposed amendment allows for less than 24 hours notice only in circumstances which are emergent or which may otherwise not reasonably be anticipated.

The requisite notice is described in proposed subsection (e). Among other things, the casino licensee must establish facts and circumstances which justify the decision to reduce supervision. Notwithstanding compliance with the proposed procedures, each licensee must at all times maintain a level of supervision which ensures the proper operation and effective supervision of all table games in the casino.

The proposed revised supervision provisions would expire six months from the effective date of the amendments.

Social Impact

The proposed amendments are expected to benefit the casino industry by allowing casino management some discretion in assigning table games staff in response to varying circumstances. Nonetheless, the caps on reduced supervision and the requisite notice procedures will ensure that such regulatory flexibility does not threaten the security or integrity of gaming operations.

Economic Impact

The proposed increases in standard staffing and the proposed plan for revised supervision should enable casino management to better utilize their supervisory personnel in response to variables such as level of play in the casino, the time of day, the number of gaming pits open, and the skill and competence level of the dealers and supervisors. The amendments should thus benefit the casino industry by permitting the exercise of sound business judgment in such day-to-day management decisions. The implementation of the proposed rules is not expected to result in any significant costs for the regulatory agencies.

Regulatory Flexibility Statement

The proposed amendments affect only the operations of casino licensees, none of which qualify as a small business as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, a regulatory flexibility analysis is not reqiured.

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

19:45-1.12 Personnel assigned to the operation and conduct of gaming and slot machines

(a) Each casino licensee shall be required to employ the [following] personnel **herein described** in the operation of its casino, regardless of the position titles assigned to such personnel by the casino licensee in its approved jobs compendium. Functions described in this section shall be performed only by persons holding the appropriate license and position endorsement required by the casino licensee's approved jobs compendium to perform such functions, or by persons holding the appropriate license and position endorsement required by the casino licensee's approved jobs compendium to supervise persons performing such functions, subject to the limitations imposed by N.J.A.C. 19:45-1.11(a).

(b) The following personnel shall be used to operate the table games in an establishment:

1. (No change.)

2. Dealers shall be the persons assigned to each craps, baccarat, blackjack, roulette, minibaccarat, red dog, sic bo and big six table to directly operate and conduct the game.

3.-4. (No change.)

5. Floorperson shall be [: i. The] **the** second level supervisor assigned the responsibility for directly supervising the operation and conduct of a craps game [at not more than two craps tables; ii. The], **and the** first level supervisor assigned the responsibility for directly supervising the operation and conduct of [gaming at not more than a total of four] **a baccarat,** blackjack, roulette, sic bo, **minibaccarat,** red dog or big six [tables or a combination thereof;] **game.**

[iii. The first level supervisor assigned the responsibility for directly supervising the operation and conduct of gaming at not more than one baccarat table; and

iv. The first level supervisor assigned the responsibility for directly supervising the operation and conduct of gaming at not more than two minibaccarat tables or a combination of one minibaccarat table and a blackjack, roulette or big six table.]

6. Pit boss shall be[: i. The] **the** third level supervisor assigned the responsibility for the overall supervision of the operation and conduct of **a** craps **game** [games at no more than eight craps tables. Nothing in this subsection shall preclude a pit boss from supervising a combination of table games including craps, blackjack, roulette, minibaccarat, big six, red dog, sic bo or baccarat, provided, however, the number of supervised tables complies with the following limitations:

Craps Games	All Other Table Games
1	9
2	8
3	6
4	4
5	3
6	2
7	1

ii. The] **and the** second level supervisor assigned the responsibility for the overall supervision of the operation and conduct of [table games at not more than a total of 12] **a** blackjack, roulette, minibaccarat, big six, sic bo, red dog or baccarat [tables or a combination thereof] **game.**

7.-8. (No change.)

[9. Each casino licensee shall staff its craps tables with at least three dealers and one boxperson per table and at least one floorperson supervising no more than two craps tables at all times while those tables are open for gaming. There shall also be at least one additional supervisor in each pit for every two craps tables at which patrons are playing. This additional supervisor shall either be a boxperson or floorperson and shall be assigned the responsibility of supervising craps tables within a pit as directed by casino management. A pit is defined as not more than eight craps tables under the supervision of a common pit boss. Examples:

i. When only two craps tables are open in a craps pit, they shall be staffed with six dealers, two boxpersons, one floorperson and one additional supervisor who shall be either a boxperson or a floorperson.

ii. When all eight craps tables are open in a pit, there shall be three dealers at each table, one boxperson at each table, one floorperson for every two tables and four additional supervisors to be used within the craps pit as directed by Casino management.]

(c) Each casino licensee shall maintain the following standard levels of staffing:

1. One casino clerk shall be assigned to not more than 24 gaming tables;

2. One dealer shall be assigned to each baccarat, blackjack, roulette, minibaccarat, sic bo, red dog and big six table;

3. Three dealers shall be assigned to each craps table;

4. One boxperson shall be assigned to each craps game;

5. One floorperson shall supervise:

i. Not more than four blackjack, roulette, minibaccarat, sic bo, red dog or big six tables, or any combination thereof; or

ii. Not more than two craps tables; or

iii. Not more than one baccarat table;

6. One pit boss shall supervise not more than 16 gaming tables.

(d) Notwithstanding the provisions of (c) above, a casino licensee may implement a plan for revised supervision by floorpersons or pit bosses, provided that each casino licensee shall at all times maintain a level of supervision which ensures the proper operation and effective supervision of all table games in the casino. In any plan for revised supervision:

1. One floorperson may supervise not more than six blackjack, roulette, minibaccarat, sic bo, red dog or big six tables, or any combination thereof;

2. One floorperson may supervise not more than two craps tables or not more than one baccarat table; and

3. One pit boss may supervise not more than 24 gaming tables.

(e) The casino manager or shift manager shall notify the principal inspector no later than 24 hours in advance of implementing or changing any plan for revised supervision, provided, however, that notice may be provided less than 24 hours in advance in circumstances which are emergent or may otherwise not reasonably be anticipated. Such notice shall include, without limitation, the following information:

1. The pit number and configuration of any pit affected;

2. The type, location and table number of any table affected;

3. The standard staffing level required for the gaming table or tables and the proposed variance therefrom;

4. The start date and time, and the duration, of the revised supervision; and

5. The basis for the decision to revise the number of supervisory personnel, which shall include any relevant factors which demonstrate that proper operation and effective supervision of the affected gaming tables will be maintained, including, as applicable, a showing:

i. That the revised supervision is justified by a reduced volume of casino play at the specified times and gaming tables;

ii. That the particular dealers or supervisors assigned to the affected tables possess a degree of skill and experience indicative of sufficient ability to operate the affected tables with revised supervision, in which case a record of the personnel assigned to such tables during the period or revised supervision shall be maintained;

iii. That a reduced number of gaming tables will be operating in the affected pits, which are in a configuration to ensure proper supervision and operation; or

iv. Any other facts or circumstances which establish that a revision in the number of supervisory personnel is appropriate.

(f) The principal inspector may, at any time upon 12 hours notice, direct that the plan for revised supervision shall be terminated and that the licensee shall maintain standard staffing levels as defined in (c) above.

(g) The provisions of (d), (e), and (f) above shall expire at the end of the sixth calendar month following the effective date of those subsections.

Recodify existing (c)-(d) as **(h)-(i)** (No change in text.)

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Removal of Slot Drop Buckets and Slot Cash Storage Boxes; Meter Readings

Proposed Amendment: N.J.A.C. 19:45-1.42

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c), 69(a) and 70(j).

Proposal Number: PRN 1992-5.

Submit comments by February 5, 1992 to:
Joyoti Fleming, Assistant Counsel
Casino Control Commission
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

The Casino Control Commission is proposing an amendment to N.J.A.C. 19:45-1.42(c)1iii, which would exempt casino security employees participating in the slot drop or slot cash storage box pickup from the requirement that all members of the slot drop team wear full-length, one-piece, pocketless garments. Also, the word "casino" was added to the term "security department" to make certain the term is correctly understood.

Presently, casino security employees taking part in the slot drop pickup and slot cash storage box removal process do not wear full-length, one-piece, pocketless garments. This practice has been in place for some time and has not caused any regulatory problems. This proposed amendment corrects the inconsistency between existing practice and the rules. The proposed amendment to N.J.A.C. 19:45-1.42(c)1iii exempts casino security officers from the requirement that members of the drop team wear the garment described in subparagraph (c)1iii when participating in the slot drop or slot cash storage box collection process.

Social Impact

There will be no social impact as a result of the proposed amendment since it only brings N.J.A.C. 19:45-1.42(c)1iii into conformity with current practice. The proposed amendment exempts casino security officers from the requirement that members of the drop team wear the garment described in subparagraph (c)1iii when participating in the slot drop or slot cash storage box collection process.

Economic Impact

There will be no economic impact as a result of the proposed amendment since it merely codifies current practice. The proposed amendment exempts casino security officers from the requirement that members of the drop team wear the garment described in N.J.A.C. 19:45-1.42(c)1iii when participating in the slot drop or slot cash storage box collection process.

Regulatory Flexibility Statement

The proposed amendment will only affect the operation of New Jersey casino licensees, none of which is a small business, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Therefore, no regulatory flexibility analysis is required.

Full text of the proposal follows (additions indicated in boldface **thus**):

19:45-1.42 Removal of slot drop buckets and slot cash storage boxes; meter readings

(a) (No change.)

(b) Procedures and requirements for removing a drop bucket or slot cash storage box from its compartment shall be the following:

1. If the drop bucket or slot cash storage box meets the requirements of N.J.A.C. 19:45-1.36(b), (c), (d) and (e):

i. (No change.)

ii. One such employee shall be a **casino** security department member; and

iii. (No change.)

2. If the drop bucket meets the requirements of N.J.A.C. 19:45-1.36(g):

i. (No change.)

ii. One such employee shall be a **casino** security department member.

(c) Procedures and requirements for removing drop buckets and slot cash storage boxes from the gaming floor shall be the following:

1. If the drop buckets and slot cash storage boxes are removed in conformity with (b)1 above:

i.-ii. (No change.)

iii. All persons participating in the drop bucket and the slot cash storage box removal procedure, except for **casino security department employees and** representatives of the Commission and Division, shall wear as outer garments only a full-length, one-piece, pocketless garment with openings only for the arms, feet and neck.

2. If the drop buckets are removed in conformity with (b)2 above:

i. (No change.)

ii. All drop buckets removed from compartments shall be transported by, at a minimum, a Commission inspector, **a casino** security department member and **a** count room supervisor directly to, and secured in, the count room for the count of the contents, except that slot cash storage boxes removed on an emergency basis shall be transported by a Commission inspector, a **casino** security department member and a cage supervisor or count room supervisor, at a minimum, directly to and secured in the count room.

(d)-(e) (No change.)

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Gaming Equipment
Slot Machines and Bill Changers; Identification; Signs; Meters
Computer Recordation and Monitoring of Slot Machines
Slot Machines and Bill Changers; Identification; Signs; Meters; Other Devices
Proposed Amendments: N.J.A.C. 19:45-1.37 and 1.44, and 19:46-1.26

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c) and 70(j).

Proposal Number: PRN 1992-4.

Submit comments by February 5, 1992 to:

Barbara A. Mattie
Chief Analyst—Operations
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

The proposed amendments would eliminate the current requirement that a bill changer contain a "cash box meter" that continuously and automatically counts the total number of bills accepted by a bill changer. The elimination of the cash box meter will not affect the ability of the Commission or the casino licensee to verify the amount of cash accepted into a bill changer as the current regulations also require a bill changer to have separate meters, known as "bill meters," that continuously and separately count the number of bills accepted by denomination.

Social Impact

The proposed amendments are not anticipated to have any social impact.

Economic Impact

It is anticipated that the proposed amendments will have a positive economic impact on casino licensees and bill changer manufacturers although it may be insignificant. The elimination of the cash box meter requirement may result in a slight savings to the manufacturer of the bill changer, which may be passed on to any casino licensee purchasing bill changers.

Regulatory Flexibility Statement

These proposed amendments will affect the operations of casino licensees, none of which is a "small business" protected under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

The proposed amendments will also affect manufacturers of bill changers (three at present), which may be small businesses. A regulatory flexibility analysis is not required because amendments do not impose any new reporting, recordkeeping or other compliance requirements on a "small business." Rather, the amendments eliminate an existing compliance requirement.

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

19:45-1.37 Slot machines and bill changers; identification; signs; meters

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

(e) Unless otherwise authorized by the Commission, each slot machine that has an attached bill changer shall be equipped with the following:

1. A mechanical, electrical or electronic device, to be known as a "change meter,"[,] that continuously and automatically counts the number of coins or slot tokens vended from the slot machine's hopper to make change; **and**

[2. A mechanical, electrical or electronic device, to be known as a "cash box meter," that continuously and automatically counts the total number of bills accepted and stored in the slot cash storage box at any given time; and]

[3.]**2.** A number of mechanical, electrical or electronic devices, to be known as "bill meters,"[,] that continuously, automatically and separately count the number of bills for each denomination of currency accepted into the bill changer.

(f)-(i) (No change.)

19:45-1.44 Computer recordation and monitoring of slot machines

(a) (No change.)

(b) The computer permitted by (a) above shall be designed and operated to automatically perform the function relating to slot machine meters in the casino as follows:

1.-6. (No change.)

7. Record the [number and] total value of each denomination of currency accepted and stored in the slot cash storage box.

(c) (No change.)

19:46-1.26 Slot machines and bill changers; identification; signs; meters; other devices

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

(d) Unless otherwise authorized by the Commission, each slot machine that has an attached bill changer shall be equipped with the following:

1. A mechanical, electrical or electronic device, to be known as a "change meter,"[,] that continuously and automatically counts the number of coins or slot tokens vended from the slot machine's hopper to make change; **and**

[2. A mechanical, electrical or electronic device, to be known as a "cash box meter," that continuously and automatically counts the total number of bills accepted and stored in the slot cash storage box at any given time; and]

[3.]**2.** A number of mechanical, electrical or electronic devices, to be known as "bill meters,"[,] that continuously, automatically and separately count the number of bills for each denomination of currency accepted into the bill changer.

(e)-(i) (No change.)

HEALTH

(a)

DIVISION OF AIDS PREVENTION AND CONTROL

State Sanitary Code

Notice of Proposal Clarification

Acquired Immunodeficiency Syndrome; Reporting of Acquired Immunodeficiency Syndrome and Infection with Human Immunodeficiency Virus

Proposed Amendments: N.J.A.C. 8:57-2.1, 2.2 and 2.3

Take notice that the Department wishes to clarify text printed as part of the proposal Summary published in the December 16, 1991 New Jersey Register at 23 N.J.R. 3735(a). The fifth paragraph should read as follows:

"Similarly, the newly promulgated rules which require that newly diagnosed infection with HIV be reportable with personal identifiers makes laboratory reporting of individual results which are indicative of HIV infection feasible and useful. Such reporting can enhance reporting of HIV infection in the manner outlined above."

(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Proposed Amendment: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council, Robert Kowalski, Chairman.
Authority: N.J.S.A. 24:6E-6(b).
Proposal Number: PRN 1992-18.

A **public hearing** concerning the proposed amendments will be held on Monday, January 27, 1992, at 2:00 P.M. at the following address:

Room 804, Eighth Floor
Department of Health
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

Submit written comments by February 6, 1992 to:

Mark A. Strollo, R.Ph., M.S.
Drug Utilization Review Council
New Jersey Department of Health
Room 501, CN 360
Trenton, New Jersey 08625-0360
609-292-1304

The agency proposal follows:

Summary

The List of Interchangeable Drug Products is a generic formulary, or list of acceptable generic drugs which pharmacists must use in place of brand-name prescription medicines, passing on the resultant savings to consumers.

Over the past thirteen years of its existence, certain medications have been added to the Formulary which are either very seldom used or are written by generic name (therefore, substitution does not pertain). At this time, specific products are proposed for deletion based on their unavailability or minimal utilization so as to make the Formulary more up-to-date and uncluttered.

Social Impact

There would be little social impact of the proposed deletions on prescribers, pharmacies or patients, because the medications would continue to be available to those who need them from other manufacturers. The proposed products are either not available or seldom prescribed.

Economic Impact

A negative impact would primarily affect the involved manufacturers, who may lose sales in New Jersey (of a magnitude not determinable) because their products would no longer be listed as susbstitutes for brand-name medications. To the extent that some medications from involved manufacturers cannot be returned to suppliers for credit, a secondary impact would also be felt by certain pharmacies that stocked these medications. However, this is counterbalanced by lack of a continuing need to keep these seldom used items in inventory.

Some patients who have benefited from the use of these medicines will have to pay higher prescription prices, but such persons can continue to receive these generics by insisting that their pharmacies stock these items and asking their physicians to write the prescription using generic terminology.

Overall, it is anticipated that very few persons will be economically adversely affected by these deletions.

Regulatory Flexibility Analysis

The proposed amendments impact many small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., specifically, over 1,500 pharmacies and several small generic drug manufacturers which employ fewer than 100 employees. However, there are no reporting, recordkeeping or other requirements imposed upon pharmacies or small generic drug manufacturers by these deletions.

Full text of the proposed amendments follows:

The following products are proposed for **deletion** from the List of Interchangeable Drug Products:

Acetohexamide tabs 250mg, 500mg	Danbury
Acetohexamide tabs 250mg, 500mg	PharmBasics
Albuterol sulfate tabs 2mg, 4mg	Amer. Ther.

Aldoclor 150 tabs substitute	Par
Aldoclor 250 tabs substitute	Par
Allopurinol tabs 100mg, 300mg	Bolar
Amitriptyline tabs 100mg, 150mg	Barr
Amitriptyline tabs 10mg, 25mg, 50mg, 75mg	Barr
Ampicillin caps 250mg, 500mg	Zenith
Atenolol tabs 25mg	Geneva
Bactrim DS tabs subtitute	Par
Bactrim injection substitute	Lemmon
Bactrim suspension substitute	PBI
Bactrim tabs substitute	Par
Bactrim tabs substitute	PBI
Berocca tabs substitute	Par
Bethanechol Cl tabs 5mg, 10mg, 25mg, 50mg	Bolar
Butabarbital tabs 15mg, 30mg	Vitarine
Carbamazepine tabs 200mg	PBI
Carisprodol tabs 350mg	Bolar
Carisprodol/ASA tabs 200/325	Bolar
Cefazolin inj. 250mg, 500mg, 1g, 5g, 10g	TEVA
Chlordiazepoxide caps 10mg, 25mg, 50mg	Zenith
Chlordiazepoxide HCl caps 25mg	Vitarine
Chlorothiazide tabs 250mg	Bolar
Chlorpromazine conc 30mg/ml	Geneva
Chlorpromazine conc 30mg/ml	PharmBasics
Chlorpromazine conc 30mg/ml	Roxane
Chlorpropamide tabs 100mg, 250mg	Barr
Chlorpropamide tabs 100mg, 250mg	Bolar
Chlorpropamide tabs 100mg, 250mg	PBI
Chlorthalidone tabs 25mg, 50mg	Bolar
Chlorthalidone tabs 25mg, 50mg	Barr
Chlorzoxazone tabs 250mg	Amide
Chlorzoxazone tabs 250mg	Geneva
Chlorzoxazone tabs 250mg	Pioneer
Clindamycin inj. 150mg/ml	Lemmon
Clofibrate caps 500mg	Chase
Clofibrate caps 500mg	Chelsea
Clofibrate caps 500mg	Novopharm
Clofibrate caps 500mg	Pharmacaps
Clonidine HCl tabs 0.1mg, 0.2mg, 0.3mg	Bolar
Clonidine HCl tabs 0.1mg, 0.2mg, 0.3mg	Amer. Ther.
Cyclandelate caps 200mg, 400mg	Amide
Cyclandelate caps 200mg, 400mg	Chelsea
Cyclandelate caps 200mg, 400mg	Geneva
Cyclandelate caps 200mg, 400mg	Inwood
Cyclandelate caps 200mg, 400mg	Lemmon
Cyclandelate caps 200mg, 400mg	Par
Cyclandelate caps 200mg, 400mg	Pioneer
Cyclandelate caps 200mg, 400mg	Sidmak
Cyclandelate caps 200mg, 400mg	Zenith
Cyclandelate caps 200mg	MD
Cyclandelate caps 200mg	West-Ward
Cyproheptadine HCl tabs 4mg	Bolar
Dicyclomine caps 10mg, tabs 20mg	Bolar
Dicyclomine HCl syrup 10mg/5ml	PBI
Dipyridamole tabs 25mg, 50mg, 75mg	Par
Disopyramide caps 100mg, 150mg	Zenith
Dolophine tabs 5mg, 10mg	Roxane
Doxepin caps 25mg, 50mg, 75mg, 100mg	Barr
Doxepin HCl oral solution 10mg/ml	Copley
Doxepin HCl oral solution 10mg/ml	PharmBasics
Doxxycycline caps 50mg, 100mg	Par
Elixophyllin KI elixir substitute	Barre-National
Elixophyllin KI elixir substitute	Berlex
Elixophyllin KI elixir substitute	Naska
Elixophyllin KI elixir substitute	PharmBasics
Equagesic tabs substitute	Par
Equagesic tabs substitute	Vitarine
Ergoloid mesylates sl. tabs 0.5mg, 1mg	Barr
Ergoloid mesylates sl. tabs 0.5mg, 1mg	Bolar
Ergoloid mesylates tabs 1mg	Barr
Ergoloid mesylates tabs oral, 1 mg	Bolar
Erythromycin estolate caps 250mg	Barr
Fenoprofen calcium caps 200mg, 300mg	Amer. Ther.
Fenoprofen calcium tabs 600mg	Amer. Ther.
Fenoprofen calcium tabs 600mg	PBI
Flufenazine HCl tabs 1mg, 2.5mg, 5mg, 10mg	Bolar
Flurazepam HCl caps 15mg, 30mg	PBI
Furosemide Oral Solution 10mg/ml	PBI
Furosemide tabs 20mg, 40mg, 80mg	Barr
Haloperidol tabs 20mg	Par
Hydralazine 10mg, 25mg, 50mg	Zenith
Hydralazine HCl tabs 10mg, 25mg, 50mg	Amer. Ther.
Hydralazine HCl tabs 25mg, 50mg	Vitarine
Hydralazine/HCTZ caps 100/50	Bolar
Hydralazine/HCTZ caps 25/25, 50/50, 100/50	Zenith
Hydrochlorthiazide tabs 25mg, 50mg, 100mg	Bolar
Hydroxazine HCl tabs 10mg, 25mg, 50mg	Amer. Ther.
Hydroxazine HCl tabs 10mg, 25mg, 50mg	PBI
Hydroxazine pamoate caps 25mg, 50mg, 100mg	Par
Imipramine tabs 10mg, 25mg, 50mg	Bolar
Isoproterenol HCl inhalation 0.5%	Dey
Isosorbide tabs oral 5mg	Zenith
Isosorbide tabs sublingual 2.5mg, 5mg	Zenith
Isoxsuprine tabs 10mg, 20mg	Zenith
Isoxsuprine tabs 10mg, 20mg	Par
Lithium citrate syrup 8mEq/5ml syrup	PharmBasics
Lomotil tabs substitute	Zenith
Lorazepam tabs 0.5mg, 1mg, 2mg	Amer. Ther.
Lorazepam tabs 1mg, 2mg	PBI
Loxapine caps 5mg, 10mg, 25mg, 50mg	Watson
Maprotiline HCl tabs 25mg, 50mg, 75mg	Bolar
Meclizine tabs 12.5mg	Zenith
Meclofenamate caps 50mg, 100mg	Amer. Ther.
Meclofenamate caps 50mg, 100mg	Barr
Meclofenamate caps 50mg, 100mg	Par
Meclofenamate caps 50mg, 100mg	PBI
Meprobamate tabs 200mg, 400mg	Zenith
Metaclopramide tabs 10mg	Bolar
Metaclopramide tabs 10mg	PBI
Methocarbamol tabs 500mg, 750mg	Zenith
Methocarbamol tabs 500mg, 750mg	Bolar
Methocarbamol tabs 500mg, 750mg	Barr
Methocarbamol tabs 500mg, 750mg	Par
Methyclothiazide tabs 2.5mg, 5mg	Bolar
Methyldopa tabs 125mg, 250mg, 500mg	Bolar
Methyldopa/HCTZ tabs 250/15, 250/25	Bolar
Methyldopa/HCTZ tabs 500/30, 500/5	Bolar
Metoclopramide tabs 10mg	Barr
Minoxidil tabs 2.5mg	PBI
Nylidrin HCl tabs 6mg, 12mg	Chelsea
Nylidrin HCl tabs 6mg, 12mg	Geneva
Nylidrin HCl tabs 6mg, 12mg	Danbury
Nylidrin HCl tabs 6mg, 12mg	Lemmon
Nylidrin HCl tabs 6mg, 12mg	Sidmak
Nylidrin HCl tabs 6mg, 12mg	USV
Nylidrin HCl tabs 6mg, 12mg	West-Ward
Nylidrin HCl tabs 6mg, 12mg	Zenith
Nystatin vaginal tabs 100,000u	Vitarine
Oxazepam caps 10mg, 15mg, 30mg	Amer. Ther.
Papaverine HCl tabs 300mg	Sidmak
Penicillin G Potassium tabs 200,000u, 400,000u	Zenith
Penicillin VK soln 125mg/5ml	Zenith
Penicillin VK tabs 250mg	Zenith
Perphenazine with amitriptyline 2/10, 2/25, 4/10	Bolar
Perphenazine with amitriptyline 4/25, 4/50	Bolar
Phenazopyridine tabs 100mg, 200mg	Barr
Phenergan Fortis syrup substitute 25mg/5ml	Barre-National
Phenybutazone tabs 100mg, caps 100mg	Chelsea
Phenybutazone tabs 100mg, caps 100mg	Geneva
Phenybutazone tabs 100mg, caps 100mg	USV
Phenybutazone tabs 100mg	Danbury
Phenybutazone tabs 100mg	Zenith
Potassium chloride liquid 10% 20mEq/15ml	Vitarine
Prazosin caps 1mg, 2mg, 5mg	Amer. Ther.
Probanthine with Phenobarb tabs substitute	Danbury
Procainamide HCl caps 250mg, 500mg	Bolar
Procainamide modified release tabs 250mg, 500mg	Bolar
Procainamide modified release tabs 750mg, 1000mg	Bolar

Prochlorperazine maleate tabs 5mg, 10mg, 25mg	Bolar
Propoxyphene caps 65mg	Barr
Propoxyphene naps/APAP 50/325	Barr
Propoxyphene naps/APAP 50/325	Bolar
Propoxyphene naps/APAP 50/325	Chelsea
Propoxyphene naps/APAP 50/325	Halsey
Propoxyphene naps/APAP tabs 50/325, 100/650	Bolar
Propranolol HCl tabs 10mg, 20mg, 40mg	Bolar
Propranolol HCl tabs 60mg, 80mg	Bolar
Quinadine gluconate extend. release tabs 324mg	Bolar
Rondec drops substitute	Hi-Tech
Spironolactone tabs 25mg	Bolar
Spironolactone tabs 25mg	Zenith
Spironolactone/HCTZ tabs 25/25	Bolar
Sprionolactone/HCTZ tabs 25/25	Zenith
Sulfamethoxazole tabs 500mg	Bolar
Sulfamethoxazole tabs 500mg	Geneva
Sulfamethoxazole tabs 500mg	Heather
Sulfamethoxazole tabs 500mg	Roche
Sulfinpyrazone tabs 100mg, caps 200mg	Barr
Sulfinpyrazone tabs 100mg, caps 200mg	Zenith
Sulfinpyrazone tabs 100mg	Danbury
Sulindac tabs 150mg, 200mg	Amer. Ther.
Temazepam caps 15mg, 30mg	Bolar
Temazepam caps 15mg, 30mg	PBI
Thioridazine HCl tabs 10mg, 15mg, 25mg	Bolar
Thioridazine HCl tabs 150mg, 200mg	Bolar
Thioridazine HCl tabs 150mg, 200mg	Par
Thioridazine HCl tabs 50mg, 100mg	Bolar
Thiothixine caps 1mg, 2mg, 5mg, 10mg, 20mg	Amer. Ther.
Timolol maleate tabs 5mg, 10mg, 20mg	Bolar
Tolazamide tabs 100mg, 250mg, 500mg	Bolar
Tolazamide tabs 100mg, 250mg, 500mg	PBI
Tolbutamide tabs 0.5g	Bolar
Trazodone tabs 50mg, 100mg	Bolar
Trazodone HCl tabs 50mg, 100mg	Amer. Ther.
Trazodone HCl tabs 50mg, 100mg	PBI
Tri-Vi-Flor chewable tabs substitute	Par
Triamcinolone acetonide cream 0.025%, 0.1%, 0.5%	PBI
Triamcinolone acetonide ointment 0.1%, 0.5%	PBI
Triamterene/HCTZ tabs 75/50	Amer. Ther.
Trifluoperazine HCl tabs 1mg, 2mg, 5mg, 10mg	Bolar
Trifluperazine HCl concentrate 10mg/ml	Geneva
Trifluperazine HCl concentrate 10mg/ml	My-K/PharmBasics
Trihexylphenidyl HCl tabs 2mg, 5mg	Bolar
Trimethoprim tabs 100mg, 200mg	Biocraft
Trimethoprim tabs 100mg	Barr
Trimethoprim tabs 100mg	Danbury
Trimipramine caps 25mg, 50mg, 100mg	PharmBasics
Tuss Ornade liquid substitute	Barre-National
Tussend Expectorant syrup substitute	Barre-National
Tussend Expectorant syrup substitute	LuChem
Tussend Expectorant syrup substitute	PharmBasics
Tussend Syrup liquid substitute	Barre-National
Tussend Syrup liquid substitute	LuChem
Tussend Syrup liquid substitute	PharmBasics
Vioform HC cream substitute 0.5%/3%	Clay-Park
Vioform HC cream substitute 1%/3%	Bausch & Lomb
Vioform HC cream substitute 1%/3%	Clay-Park
Vioform HC cream substitute 1%/3%	NMC
Vioform HC cream substitute 1%/3%	Syoset
Vioform HC cream substitute 1%/3%	Thames
Vioform HC ointment substitute 1%/3%	Clay-Park
Viokase tabs substitute	Anabolic

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DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Proposed Amendments: N.J.A.C. 8:71

Authorized By: Drug Utilization Review Council, Robert Kowalski, Chairman.
Authority: N.J.S.A. 24:6E-6(b).
Proposal Number: PRN 1992-19.

A **public hearing** concerning the proposed amendments will be held on Monday, January 27, 1992, at 2:00 P.M. at the following address:

Room 804, Eighth Floor
Department of Health
Health-Agriculture Bldg.
Trenton, New Jersey 08625-0360

Submit written comments by February 6, 1992 to:

Mark A. Strollo, R.Ph., M.S.
Drug Utilization Review Council
New Jersey Department of Health
Room 501, CN 360
Trenton, New Jersey 08625-0360
609-292-4029

The agency proposal follows:

Summary

The List of Interchangeable Drug Products is a generic formulary, or list of acceptable generic drugs which pharmacists must use in place of brand-name prescription medicines, passing on the resultant savings to consumers.

For example, the proposed nifedipine 10mg and 20mg capsules could then be used as a less expensive substitute for Procardia, a branded prescription medicine. Similarly, the proposed nadolol 40mg, 80mg and 120mg tablets could be substituted for the more costly branded product, Corgard.

The Drug Utilization Review Council is mandated by law to ascertain whether these proposed medications can be expected to perform as well as the branded products for which they are to be substituted. Without such assurance of "therapeutic equivalency," any savings would accrue at a risk to the consumer's health. After receiving full information on these proposed generic products, including negative comments from the manufacturers of the branded products, the advice of the Council's own technical experts, and data from the generics' manufacturers, the Council will decide whether any of these proposed generics will work just as well as their branded counterparts.

Every proposed manufacturer must attest that they meet all Federal and State standards, as well as having been inspected and found to be in compliance with the U.S. Food and Drug Administration's regulations.

Social Impact

The social impact of the proposed amendments would primarily affect pharmacists, who would need to either place in stock, or be prepared to order, those products ultimately found acceptable.

Many of the proposed items are simply additional manufacturers for products already listed in the List of Interchangeable Drug Products. These proposed additions would expand the pharmacist's supply options.

Physicians and patients are not adversely affected by this proposal because the statute (N.J.S.A. 24:6E-6 et seq.) allows either the prescriber or the patient to disallow substitution, thus refusing the generic substitute and paying full price for the branded product.

Economic Impact

The proposed amendments will expand the opportunity for consumers to save money on prescriptions by accepting generic substitutes in place of branded prescriptions. The full extent of the saving to consumers cannot be estimated because pharmacies vary in their prices for both brands and generics.

Some of the economies occasioned by these amendments accrue to the State through the Medicaid, Pharmaceutical Assistance to the Aged and Disabled Program, and prescription plan for employees. A 1988 estimate of average savings per substituted Medicaid prescription was $7.31. However, the number of prescriptions that will be newly substituted due to these proposed amendments cannot be accurately assessed in order to arrive at a total savings.

Regulatory Flexibility Analysis

The proposed amendments impact many small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:15B-16 et seq., specifically, over 1,500 pharmacies and several small generic drug manufacturers which employ fewer than 100 employees.

However, there are no reporting or recordkeeping requirements for pharmacies, and small generic drug manufacturers have minimal initial reports, and no additional ongoing reporting or recordkeeping requirements. Further, these minimal requirements are offset by the increased economic benefits accruing to these same samll generic businesses due to these proposed amendments.

Full text of the proposed amendments follows:

Amatadine HCl Syrup 50mg/5ml	Copley
Amiloride/HCTZ tabs 5/50	Mylan
Amoxapine tabs 25mg, 50mg, 100mg, 150mg	Danbury
Atenolol tab 25mg	Geneva
Atenolol tabs 50mg, 100mg	Danbury
Atenolol tabs 50mg, 100mg	Mylan
Atenolol/chlorthalidone tabs 50/25, 100/25	Danbury
Bromocriptine mesylate tabs 2.5mg	Danbury
Chlorzoxazone tabs 250mg, 500mg	Ohm
Clorazepate tabs 3.75mg, 7.5mg, 15mg	Danbury
Desipramine HCl tabs 10mg, 25mg, 50mg	Danbury
Desipramine HCl tabs 75mg, 100mg, 150mg	Danbury
Fiorinal tabs substitute	Danbury
Fluphenazine HCl tabs 1mg, 2.5mg, 5mg, 10mg	Danbury
Fluphenazine HCl Oral Soln 5mg/ml	Copley
Gemfibrozil caps 300mg	Danbury
Granulex spray substitute	Armstrong
Guaifenesin tabs 600mg	DURA
Ibuprofen tabs 300mg	Danbury
Inflamase Mild ophth soln substitute 0.125%	Steris
Inflamase Forte ophth soln substitute 1%	Steris
Isosorbide Dinitrate tabs 20mg, 30mg, 40mg	Danbury
Loperamide HCl caps 2mg	Danbury
Loperamide HCl caps 2mg	Mylan
Loxapine succinate caps 5mg, 10mg, 25mg, 50m	Danbury
Methylprednisolone tabs 4mg, 16mg	Danbury
Metoclopramide HCl tabs 5mg	Danbury
Metaproterenol sulfate syrup 10mg/5ml	Copley
Minocycline HCl caps 50mg, 100mg	Danbury
Minocycline HCl tabs 50mg, 100mg	Danbury
Nadolol tabs 40mg, 80mg, 120mg	Danbury
Nifedipine caps 10mg, 20mg	Miles
Nitrofurantoin caps 25mg, 50mg, 100mg	Danbury
Nortryptylline HCl caps 10mg, 25mg, 50mg, 75mg	Danbury
Poly-Vi-Flor with Iron tabs 0.5mg substitute	Copley
Phos-flur oral rinse substitute	Danbury
Propoxyphene naps/APAP tabs 100/650	Danbury
Propranolol/HCTZ tabs 40/25, 80/25	Danbury
Propatheline Bromide tabs 15mg	Danbury
Spironolactone tabs 25mg, 50mg, 100mg	Danbury
Spironolactone/HCTZ tabs 50/50	Danbury
Temezepam caps 15mg, 30mg	Danbury
Tolmetin sodium caps 400mg	Purepac
Tolmetin sodium caps 400mg	Danbury
Tolmetin sodium tabs 200mg	Danbury
Trazodone HCl tabs 150mg	Danbury
Zenate Prenatal Vitamin substitute	Copley

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DIVISION OF FAMILY HEALTH SERVICES

Eligibility Criteria; HealthStart Plus

Proposed New Rules: N.J.A.C. 8:80

Authorized By: Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health.

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5.

Proposal Number: PRN 1992-7

Submit comments by Wednesday, February 5, 1992, to:

Ms. Susan Lenox Goldman
Acting Assistant Commissioner
Division of Family Health Services
CN 364
Trenton, New Jersey 08625-0364

The agency proposal follows:

Summary

These new rules are proposed, pursuant to N.J.S.A. 26:2H-18.24, to establish consumer eligibility criteria for enrollment in HealthStart Plus. In 1991, N.J.S.A. 26:2H-18.24 was enacted to include certain measures for health care cost containment (see P.L.1991, c.187). This included the establishment of a special fund known as the Health Care Cost Reduction Fund. Monies from this fund were appropriated to support several initiatives to reduce health care costs. One of the initiatives was the establishment of HealthStart Plus, a program for pregnant women and infants up to one year of age, whose income is between 185 percent and 300 percent of the poverty level. The purpose of this program is to improve health outcomes for uninsured pregnant women and infants, thereby decreasing overall health costs to the New Jersey Health Care Trust Fund. This will be accomplished by reducing the incidence of preventable health problems through preventive and primary health care services to this population. This program is not an entitlement; the number of persons participating in this program will be limited to the number that can be served by the amount of the appropriation and the specific allocation of funds to support maternity services and specific allocation to support pediatric services.

Social Impact

The proposed rules will provide access to a program of maternity and pediatric services to New Jersey families: (1) whose incomes are at or less than 300 percent of the Federal poverty level, (2) who are not eligible for New Jersey Medical Assistance and Health Services programs (Medicaid), and (3) who do not have comparable health care insurance. A significant number of these families do not have adequate disposable income to purchase health care insurance and frequently work in industries that do not provide health care insurance as an employment benefit. In general, families with incomes greater than 300 percent of the poverty level have the means to purchase health care insurance or frequently receive health care insurance as an employment benefit. The health care services made available by the proposed rules will increase the likelihood of positive birth outcomes and infant health status for persons participating in this program by providing access to primary and preventive health care. Lack of access to adequate prenatal and pediatric care is associated with poor health indicators such as: low birth weight, increased infant mortality and morbidity and lack of appropriate immunization status. Access to adequate health care should improve birth outcomes and child health status, which will have a positive impact on the child's future development and learning.

Economic Impact

The proposed rules are expected to produce a net decrease in costs to the New Jersey Health Care Trust Fund. National studies have established that for every dollar spent on prenatal care there is a savings of three dollars; for every dollar spent on immunization, there is a cost savings of ten dollars in later health care costs. The proposed rules impose no additional costs on health care providers. The participants in the program will be required to participate in the cost of the service but at a rate well below the market rate of comparable services. This program will make health care economically accessible to families with incomes between 185 percent and 300 percent of the Federal poverty line.

Regulatory Flexibility Analysis

The proposed rules provide the client eligibility and appeal requirements for the HealthStart Plus program, which is provided to eligible participants on a first-come, first-served basis by approximately 19 Health Maintenance Organizations (HMO) operating within the State of New Jersey. Most of these HMO's can be considered small businesses, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules require the HMO's to evaluate the eligibility for service of applicants, based upon standards provided in the rules. No professional education or experience is required to perform the evaluation, which is based upon the applicant's completion of a form provided by the Department to the HMO. Since the staffing requirements are minimal, and it is important that all applications be evaluated uniformly, the Department has not made any differentiation based on business size in the rules.

Full text of the proposal follows:

CHAPTER 80
HEALTHSTART PLUS

SUBCHAPTER 1. GENERAL PROVISIONS

8:80-1.1 Purpose; scope

Healthstart Plus is funded through a limited appropriation and is contingent on the availability of those funds and the amount allocated by the Department of Health to support specific services for the purpose of improved health outcomes for under insured pregnant women and their infants through the provision of preventive and primary health care services:

8:80-1.2 Definitions

For the purpose of this chapter, the following words, phrases, names and terms shall have the following meanings:

"Authorized eligibility worker" means an employee of the health provider authorized by the Department of Health to provide HealthStart Plus.

"Comparable insurance" means a third party resource for payment of health care costs for preventive and primary ambulatory care, including prenatal care, and inpatient care.

"Family income" means the income of the pregnant woman and her spouse or the parents' or legal guardians' income for the child for the 12 months immediately proceeding the date of application. In the event the spouse is not living in the household, the spouse's income may be excluded from calculation of the household income upon presentation of a signed statement by the mother that the spouse does not contribute to the household income.

"HealthStart Plus" means a package of comprehensive maternity and pediatric health care services delivered by a provider authorized by the Department of Health; the funding source expires on June 30, 1993. HealthStart Plus maternity services include prenatal care, delivery and post partum care up to end of the calendar month of the sixtieth day of the end of the pregnancy. HealthStart Plus pediatric care includes newborn care and comprehensive health care to the end of the calendar month of the child's first birthday.

"Liquid assets" means cash, certificates of deposit, government bonds and other marketable securities which are readily converted to cash.

"Poverty level" means the Federal poverty income guidelines published annually in the "Federal Register" by the U.S. Department of Health and Human Services. The most recently published guidelines shall be used to determine eligibility.

"Total family income" means the combined wages, alimony, interest and all other earnings as required to be reported on the most recent US Tax 1040 form as gross income for the pregnant woman and her spouse or the parent's or legal guardians of the child.

SUBCHAPTER 2. ELIGIBILITY

8:80-2.1 Eligibility requirements

(a) In order to be enrolled for HealthStart Plus services, a completed application must be received by provider(s) authorized by the Department of Health to provide HealthStart Plus services no later than February 28, 1994. Application forms shall be available from provider(s) authorized by the Department of Health to provide HealthStart Plus services. Applications for HealthStart Plus shall include, but not be limited to, the following information:

1. Name and address of applicant;
2. Date the applicant began to reside in the State;
3. Date of birth of the applicant;
4. Place of birth and date of discharge from the hospital following birth for applicants who are children less than one year of age;
5. Estimated date of delivery and the name and address of any health care provider of any prenatal care rendered for this pregnancy, if the applicant is a pregnant woman;
6. The name of any health care benefits program or health care insurance, including New Jersey Medical Assistance and Health Services, from which the applicant is entitled to receive benefits;
7. A description of the benefits the applicant is entitled to under any health care benefits plan or health care insurance and the name and telephone number of a contact person who can verify these benefits;
8. Total family income for the previous 12 months;
9. Submission of appropriate documentation of income for the most recent tax year; and
10. Statement of type and value of all the family's liquid assets.

(b) Eligibility for HealthStart Plus is limited to pregnant women and the infants born of those pregnancies and children less than one year of age. Once eligibility has been determined, the pregnant woman shall remain eligible for and enrolled in HealthStart Plus until the last day of the calendar month in which the 60th post partum day occurs. For the child, born to a pregnant women who was enrolled in HealthStart Plus, eligibility and enrollment shall be automatic at the time of birth unless the mother requests that no enrollment occur. For children, eligibility and enrollment for HealthStart Plus end on the last day of the calendar month in which the child's first birthday occurs.

(c) In order to be eligible for HealthStart Plus services, a pregnant woman must be a resident of the State of New Jersey. For the child born to a resident of New Jersey but whose mother was not enrolled in HealthStart Plus, the child shall be considered a resident of the State 14 days after discharge from the hospital or birthing center to his or her parent(s)' or legal guardian's home in the State. For the child who moves to New Jersey, the child will be considered a resident once he has resided in New Jersey for a full calendar month. Neither citizenship nor alien status shall be considered in eligibility determination.

(d) If a pregnant woman or child has comparable health insurance coverage, such individuals shall not be eligible for HealthStart Plus services. If the individual has third party health care coverage but that coverage is not comparable, eligibility will exist for the uncovered services. In this event, as a condition of eligibility, the family is required to provide all health care coverage information to the health care provider designated by the Department to provide HealthStart Plus services as is necessary to coordinate benefits. HealthStart Plus is the payor of last resort and will not provide payment for services that are included in any other health care coverage for the pregnant women or child.

(e) The pregnant woman or the parents or legal guardian of the child family must agree to pay 10 percent of the premium cost of each family member enrolled in HealthStart Plus to the health care provider designated by the Department to provide HealthStart Plus services.

(f) The total family income shall not exceed 300 percent of the poverty level for the household size and liquid assets shall not exceed $4,500. For the pregnant woman, the household includes her spouse, the unborn child, her children and her spouse's children under the age of 21 residing in the same household. The income of the parents of a pregnant woman shall not be considered in determining eligibility. Once income eligibility is established for the pregnant woman, the child born of that pregnancy shall automatically be deemed income eligible for the first 12 months of life. For a child, the household includes the child's parents or legal guardians and blood-related siblings (including half-blood).

(g) As a condition of eligibility for HealthStart Plus, the family shall present upon application adequate documentation of total family income sufficient for the authorized eligibility worker to determine income eligibility for the program. Adequate documentation may include, but is not limited to, a copy of the most recent U.S. Tax 1040 form of the family. If the U.S. Tax 1040 form from the most recent year is not available, or if income has significantly changed from the income reflected on the U.S. Tax 1040 form, copies of unemployment benefits checks or statements, copies of the four consecutive weeks' paystubs from the immediately proceeding four weeks or a statement from the employer may be substituted.

(h) No child or pregnant woman who is receiving (or would be eligible for benefits if he or she applied) benefits through New Jersey Medical Assistance and Health Services Program(s) shall be eligible for HealthStart Plus services.

(i) A pregnant woman, requesting transfer from a hospital-based prenatal care provider, who is at or beyond the 28th week of pregnancy, shall be ineligible for HealthStart Plus.

(j) As a condition of eligibility, the pregnant women or parents/legal guardians of the child agree to consent to the release of medical records to the Department of Health that are necessary to evaluate the impact of this program and service delivery.

SUBCHAPTER 3. APPEALS

8:80-3.1 Appeals process

(a) The following applies to first level appeals:

1. Upon receipt of an ineligibility determination by the authorized HealthStart Plus provider, the applicant may make appeal of such determination to the Department by filing a written appeal addressed to:

New Jersey State Department of Health
HealthStart Plus Program
CN 364
363 West State Street
Trenton, New Jersey 08625

2. The appeal shall comply with the following requirements:

i. The appeal shall be in writing;

ii. The written appeal must include all reasons for the appeal and any documentation or proof in support thereof; and

iii. Appeals must be received by the State Office no later than 14 days from the date of the determination of ineligibility made by the HealthStart Plus provider.

3. Upon receipt of the appeal, the Department shall:

i. Acknowledge receipt of the appeal in writing to the applicant within 14 days;

ii. Conduct such review and analysis as is necessary to determine if there is a basis for the claim; and

iii. Issue a written determination to the applicant within 30 days of original receipt of the appeal.

(b) The following applies to second level appeals:

1. Upon receipt of a determination by the Department HealthStart Plus, an applicant who wishes to further dispute such determination may appeal to the State Commissioner of Health by submitting a written appeal to:

New Jersey State Department of Health
HealthStart Plus
John Fitch Plaza
CN 360
Trenton, New Jersey 08625-0360
ATTN: State Commissioner of Health

2. Appeals must be received at the above address no later than 14 days from the date of determination made by the HealthStart Plus Program.

3. The written appeal shall include all reasons and grounds for disputing the HealthStart Plus Program determination, and all proof and documentation in support of the appeal.

4. The State Commissioner of Health shall either direct the Department staff to conduct such review and analysis as is necessary to reach a decision on the appeal, and may direct a conference be held with the applicant, or may refer the matter to the Office of Administrative Law pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

5. Except for appeals referred to the Office of Administrative Law, the State Commissioner of Health shall issue a decision on the appeal within 45 days from the date of original receipt of the appeal. Appeals referred to the Office of Administrative Law shall be decided by the State Commissioner of Health within 45 days from the date of filing of the Initial Decision of the Administrative Law Judge.

6. Decisions made by the State Commissioner of Health shall be final, with subsequent appeal to the Superior Court of New Jersey as permitted by court rules.

(c) Applicants may not receive HealthStart Plus benefits while an appeal is pending at any level.

HUMAN SERVICES

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DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration Manual
Prepaid Health Plans

Proposed Repeal and New Rules: N.J.A.C. 10:49-10

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-3h; 30:4D-6b(17); 30:4D-7, 7a, b and c, r; 30:4D-12, 42 CFR 434.

Proposal Number: PRN 1991-566.

Submit comments by February 5, 1992 to:

Henry W. Hardy, Esq.
Administrative Practice Officer
Division of Medical Assistance and Health Services
CN 712
Trenton, NJ 08625

The agency proposal follows:

Summary

The Department of Human Services proposes to delete the current text of N.J.A.C. 10:49-10 and replace it with new text. The purpose of these rules is to describe the terms and conditions for prepaid health plans that participate in the New Jersey Medicaid Program. A health maintenance organization (HMO) is a type of prepaid health plan (PHP). The Division's rules are based on the Federal regulations governing HMO's and PHP's (42 CFR 434). An HMO can be either a public or private organization organized under state law which is either a Federally qualified HMO or one that meets the State's definition of an HMO.

The basic provisions regarding recipient eligibility and enrollment in an HMO remain the same. The recipient's eligibility is established by a county welfare agency (CWA) pursuant to N.J.A.C. 10:49-1.1. The recipient is eligible to receive Medicaid services in the traditional manner by going to individual Medicaid providers who render medically necessary services. If recipients voluntarily elect to participate in an HMO, they are called "enrollees." They receive the services offered by the HMO under medical case management. Medicaid eligible enrollees are guaranteed six months of Medicaid eligibility on initial enrollment. Services outside the scope of the HMO contract would be available to the recipient/enrollee through the traditional Medicaid program (see N.J.A.C. 10:49-1.4).

With respect to the providers of service, called an HMO or prepaid health plan, they are under contract with the State of New Jersey, Department of Human Services, to provide a package of services to Medicaid enrollees at a prepaid capitation rate. The providers' duties and responsibilities are specified in the Federal regulations cited above, these proposed rules, and the contract executed between the parties.

The initial discussion in this Summary is basically a restatement of existing policy regarding providers' and enrollees' rights and responsibilities. However, there are some new concepts being presented in these new rules which are discussed towards the end of the Summary just above the Social Impact statement.

The basic concept of a PHP is that an individual pays a premium and receives a package of services. With respect to Medicaid, the State of New Jersey pays a premium, or capitation rate, to the PHP, which provides services to the Medicaid recipients that are enrolled.

The term "contractor" has a specific meaning within N.J.A.C. 10:49-10. A "contractor" is an HMO or PHP that contracts with the Department of Human Services to provide comprehensive health care services to Title XIX Medicaid recipients on a prepayment basis.

The proposed new rules set forth the requirements for a contractor contracting with the department (see N.J.A.C. 10:49-10.2). The "contractor" must comply with the requirements of the New Jersey Certificate of Authority which is issued by the New Jersey Department of Health.

In addition, the contractor must have approval from the Federal Department of Health and Human Services, Health Care Financing Administration (HCFA). The contractor must also have administrative capabilities, provide certain information on each principal, and identify and provide financial disclosure of subcontractors with whom it has business transactions in excess of $25,000 per year.

The contractor can enter into either a risk contract or non-risk contract with the Department. A risk contract means that the contractor is at risk if the cost of providing services exceeds the payments made by the agency. A non-risk contract means that the contractor is not at risk if the cost of services exceeds the payment made by the agency. Providers who enter into risk contracts are required to provide certain services.

The scope of benefits available to Medicaid recipients are those specified in the contract between the agency and the PHP.

With respect to recipients, an "enrollee" or "enrolled recipient" means an individual who is eligible for Medicaid residing within the defined market area, has voluntarily elected to participate in the contractor's plan, and meets specific Medicaid eligibility requirements for plan enrollment agreed to by the department and the contractor.

Enrollment shall be six-month periods pursuant to Federal law (Section 1903(m)(2)(F) of the Social Security Act, identified as 42 USC 1396b). During the first 30 days of each six-month enrollment period, the enrollee may disenroll from the contractor's plan upon written notification and without cause. After this time period, the enrollee may have to invoke the grievance process to disenroll. The contractor may terminate the enrollee's enrollment for reasonable cause through the grievance process.

If a Medicaid patient who is enrolled in a PHP needs additional Medicaid services, the patient can obtain them from an approved Medicaid provider. Medicaid patients do not lose their entitlement to any Medicaid service that is medically necessary by virtue of their enrolling in a PHP. The rules also identify limitations and/or exclusions which apply to the Medicaid program generally and to persons enrolled in a PHP. (see N.J.A.C. 10:49-1.3(c) and (d)).

It is important to distinguish between a non-covered HMO service and a non-covered Medicaid service. The former means that the HMO does not provide a particular service(s) which would be available under the regular Medicaid program. The HMO enrollee could obtain the covered Medicaid service, when medically necessary, in the same manner as any other Medicaid recipient.

A non-covered Medicaid service means a service not covered by Title XIX and is not reimburseable by Medicaid, regardless of whether the recipient is or is not enrolled in an HMO/PHP. A contractor, however, may provide a non-covered Medicaid service at its own expense.

With respect to marketing and enrollment, (see N.J.A.C. 10:49-10.4) the Director, Division of Medical Assistance and Health Services, must give written approval to informational and instructional materials. The marketing materials must clearly indicate that HMO enrollment is voluntary. In addition, no form of compensation or reward may be given to an eligible Medicaid patient as an inducement to enroll.

Once the patient becomes enrolled, the contractor is required to provide the patient (enrollee) an identification card, specific details on benefits, limitations, etc., the procedures for obtaining benefits, the process for resolving complaints, and the procedures for disenrollment.

Disenrollment of Medicaid recipients can occur when the patient loses eligibility or moves outside the market area; when the contract between the Department and the contractor is terminated; or through formal grievance. The Medicaid patient could still receive Medicaid services from Medicaid providers other than the PHP, except where disenrollment is due to ineligibility.

The contractor is required to have a full-time administrator, but this administrator does not have to devote all his or her time to the Medicaid contract.

The contractor is also required to maintain comprehensive medical records on each patient, and to make the records available upon request. The contractor shall maintain the confidentiality of each patient's records.

The contractor shall maintain a system of quality assurance, and shall agree to medical audits as required by the State and Federal regulations.

The contractor shall establish a grievance procedure for receiving and resolving any complaints from enrollees relating to quality, scope, nature and delivery of services. This grievance procedure is not intended to be a substitute for the fair hearing procedure set forth in N.J.A.C. 10:49-5. A Medicaid recipient is still entitled to request a hearing on issues that would be considered a contested case (see N.J.A.C. 1:1-2.1, Definitions).

The following concepts are newly presented in these new rules. The term "stop loss" means a limit to financial liability of the contractor for services provided under a risk contract. For example, if the need for a stop loss is established and agreed to by the Department and the limit is negotiated at $25,000, that is, stop loss of $25,000 per person per year, then if the cost of services provided an enrollee reached $25,000, the Division would be responsible for paying for all other services rendered during the balance of the year for that individual. The intent is to limit the HMO provider's liability via the contract. (see N.J.A.C. 10:49-10.7(e)).

There are contract sanctions specified in N.J.A.C. 10:49-10.10. These provisions are pursuant to Federal law cited in the text. In addition to the requirements of program participation set forth in N.J.A.C. 10:49-1.17, which contains provisions governing suspension, debarment and disqualification, the Division may impose the four sanctions listed in N.J.A.C. 10:49-10.10(a)1 through 4.

The four sanctions are a letter of admonishment, suspension of further enrollments and one or more marketing activities, a withholding of all or part of the capitation payments or termination of the contract.

The Division is required to give written notice to the provider whenever sanctions are imposed.

In addition to the sanctions that can be imposed by the Division, the Federal Government, through the Secretary, Department of Health and Human Services, may impose civil money, penalties if the contractor (prepaid health provider) violates the provisions of N.J.A.C. 10:49-10.10(d)1 through 4.

The four violations are failure to provide required medically necessary services that have or may adversely affect enrollees, imposing premiums in excess of those allowed by law, discrimination among enrollees on the basis of their health status, or refusing to re-enroll an enrollee if their medical condition or history indicates a need for substantial future medical services, or misrepresents or falsifies information.

Social Impact

The proposed repeals and new rules impact on those Medicaid patients who choose to enroll in a PHP. These eligibles are entitled to those Medicaid services that are provided by the PHP. If the Medicaid recipient needs a Medicaid covered service that is not provided by the PHP, then the service would be available from a participating Medicaid provider. Medicaid recipients do not lose any Medicaid coverage by enrolling in an HMO. Medicaid recipients may disenroll by following the proper procedure.

The proposed repeals and new rules also impact on PHP's, or HMO's, that participate in the New Jersey Medicaid Program. These providers must follow the Federal regulations cited above, the State rules currently in existence or subsequently adopted, and all other applicable Federal and/or State regulations.

Medicaid enrollees may be affected positively because the proposed rules on sanctions prohibits providers from charging any premium(s). In addition, providers may not discriminate against enrollees or re-enrollees for health reasons.

Providers may be affected by the four sanctions listed in the new rules. Providers who violate the sanctions will be subject to penalties contained in these rules, as well as any other penalties that may be imposed pursuant to State or Federal law. The sanctions only become operative in the event where one or more violation(s) occur.

Economic Impact

The Division reimburses PHP's on a prepaid capitation basis. They are not paid on a fee-for-service basis. This means that the Division negotiates a rate with the PHP based on the services covered and population enrolled, and pays a monthly premium. The prepaid capitation rate cannot exceed the Medicaid fee-for-service upper limit.

There is no cost to the Medicaid patient. He or she is not responsible for paying the monthly premium.

The proposed new rules result in no different economic impact than the current rules.

Regulatory Flexibility Analysis

The proposed repeals and new rules do impact on small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., because PHP's may employ less than 100 full-time employees. The requirements contained in the proposed new rules are based on the Federal regulations cited above and apply equally to all providers. In addition, the Subpart D of the Federal regulations imposes requirements on the state Medicaid agency to provide for a system of periodic medical audits, to identify and collect management data, which must, at a minimum, include reasons for enrollment and termination, and use of services (42 CFR 434.50-63, subpart D). These provisions were not included in the text of the State's rule because they are provider requirements. However, since the State is required to obtain necessary data regarding services and payment, PHP's are required to comply with the reporting, recordkeeping and other compliance requirements sets forth in the proposed new rules. The reporting and recordkeeping requirements pertain to the areas of enrollee identification data, marketing and enrollment, utilization data for covered services, financial data and third party recoveries. Other compliance requirements include those related to provider organization and personnel, and the need to obtain a Department of Health Certificate of Authority. The State has no discretion to waive the Federal requirements.

In addition, Medicaid providers are required by State law to maintain sufficient records to fully document the name of the patient being treated, dates and nature of services, etc. (see N.J.S.A. 30:4D-12).

The Division has tried to minimize any adverse impact on providers by framing the requirements in terms of medical records which would normally be maintained by a provider of medical services.

There are no capital costs associated with the proposed new rules. The reason there are no capital costs associated with rules is that prepaid health providers include administrative costs as a component in their data they submit to establish a capitation rate. One of the cost elements includes reporting and recordkeeping requirements. These new rules impose no requirements on providers.

The Division believes the reporting, recordkeeping and other requirements are necessary for the health, safety and welfare of the Medicaid patients enrolled in PHP's and to insure receipt of Federal matching funds.

Full text of the rules proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:49-10.

Full text of the proposed new rules follows:

SUBCHAPTER 10. PREPAID HEALTH CARE SERVICES; TITLE XIX ELIGIBLES

10:49-10.1 Definitions

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

"Benefits" means medical, psychiatric and related health services which the contractor has agreed to provide, arrange for and be held fiscally responsible for under the negotiated contract. The benefit package that must be provided by the contractor under the terms of the contract is specified in N.J.A.C. 10:49-10.3(a)1.

"Capitation rate" means a stated sum due the contractor for a stated group of services for each enrollee.

"Commissioner" means the Commissioner of the Department of Human Services or a duly authorized representative.

"Contractor" means a health maintenance organization or prepaid health plan as defined herein which contracts with the Department for the provision of comprehensive health care services to Medicaid enrollees on a prepayment basis.

"CWA" or "county welfare agency" means a government agency that determines eligibility to receive financial assistance and Medicaid benefits.

"Department" means the Department of Human Services.

"Director" means the Director of the Division of Medical Assistance and Health Services or a duly authorized representative.

"Disenrollment" means the process of removal of an enrollee from the contractor's plan, not from the Medicaid Program.

"Division" means the Division of Medical Assistance and Health Services of the Department.

"Emergency services" means those services required to treat a life-threatening or organ-threatening condition or potentially life- or organ-threatening condition of such immediate nature that any unusual delay in treatment would be dangerous to the health or well-being of the enrollee.

"Enrollee" or "enrolled recipient" means an individual who is eligible for Medicaid residing within the defined market area, who elects or has had elected on his or her behalf by an authorized person, in writing, to participate in the contractor's plan and meets specific Medicaid eligibility requirements for Plan enrollment agreed to by the Department and the contractor.

"Enrollment" means the process by which individuals eligible for Medicaid voluntarily contract to utilize prepaid health care services in lieu of standard Medicaid benefits.

"Enrollment area" means the boundaries established by Zip Code, within which the HMO will limit its enrollment.

"EPSDT" means Early Periodic Screening, Diagnosis and Treatment mandated by Title XIX of the Social Security Act.

"Federally qualified HMO" means an HMO that has been determined by the Public Health Service (PHS) to be a qualified HMO under section 1310(d) of the PHS Act.

"Health maintenance organization" (HMO) means a public or private organization, organized under State law which:

1. Is a Federally qualified HMO (defined above); or

2. Meets the State Plan's definition of an HMO which includes, at a minimum, the following requirements:

(a) Is organized primarily for the purpose of providing health care services;

(b) Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to non enrolled Medicaid eligible individuals within the area served by the HMO; and

(c) Makes provision, satisfactory to the Division, against the risk of insolvency, and assures that Medicaid enrollees will not be liable for the HMO's debts if it does become insolvent.

"HHS" or "DHHS" means the Department of Health and Human Services of the Federal government.

"IPN" means independent practitioner network which is one of the types of HMO operation. Services are provided for enrollees in the individual offices of the contracting physician case managers (PCMs).

"Market area" means the defined geographic area within which potential enrollees shall reside.

"Marketing" means any presentation by or on behalf of an HMO for enrollment purposes.

"Medicaid" refers to the program funded under Title XIX of the Social Security Act administered by the Department.

"Medicaid recipient" means an individual eligible to receive services under the New Jersey Medicaid Program as authorized by State and Federal law and amendments thereto.

"Non-covered HMO services" means services not covered in the contractor's benefits package included under the terms of the Medicaid contract.

"Non-covered Medicaid services" means all services not covered under the New Jersey State Plan for the Medicaid Program.

"Nonrisk" means that the contractor is not at financial risk for changes in the cost or utilization of services provided for in the payment rate agreed upon at the beginning of the contract period. Under a nonrisk contract, the State agency may make retroactive adjustments during and at the end of the contract period so that the contractor is reimbursed for costs actually incurred, subject to the upper limit of payment established in 42 CFR 447.362, or any lower limit specified in the contract.

"PCM" means physician case manager which is the primary care physician.

"Plan" means all services and responsibilities undertaken by the contractor pursuant to the contract.

"Prepaid health plan (PHP)" means an entity that provides medical services to enrollees, under a contract with the Medicaid agency and on the basis of prepaid capitation fees, but does not necessarily qualify as an HMO.

"Primary care physician" means a physician who has the responsibility for general care and treatment and for initiating referrals for specialist care and for maintaining continuity of patient care. In general, the primary care physician is a general or family practitioner, internist, pediatrician, or obstetrician/gynecologist.

"Referral/services" means those health care services rendered outside of the contractor's facilities or IPN when ordered and approved by the contractor.

"Risk" or "underwriting risk" means the possibility that a contractor may incur a loss because the cost of providing services may exceed the payments made by the agency to the contractor for services covered under the contract.

"Service area" means the geographic area in which the contractor is obligated to provide covered services for its Medicaid enrollees under its contract.

"Stop-loss" means a limit to financial liability of the contractor for services provided under a risk contract. The need, applicability and amount of a stop-loss are negotiable and specified in the contract.

"Subcontract" means any written agreement between the contractor and a third party to perform a specified part of the contractor's obligations under the contract.

"Subcontractor" means any third party who has a written agreement with the contractor to perform a specified part of the contractor's obligations, and is subject to the same terms, rights, and duties as the contractor.

"Target population" means the population from which the initial number of enrollees, not to exceed any limit specified in the contract, will be drawn, that is, individuals eligible for Medicaid residing within the stated market area and belonging to one of the categories of eligibility for Medicaid to be covered under the contract.

"Termination" means the loss of Medicaid eligibility and therefore automatic disenrollment from the HMO if beyond the guaranteed eligibility period.

10:49-10.2 Criteria for contracting with the Department

(a) In contracting with the Department, the contractor shall:

1. Comply with the requirements of the New Jersey certificate of authority (N.J.S.A. 26:2J-1 et seq.) statutes and regulations;

2. Provide to the Division of Medical Assistance and Health Services, Department of Human Services, a copy of the Department of Health approved Certificate of Authority and application document on request;

3. Furnish the Department with such information and reports that the Department finds necessary and maintain records as required by the Department, State and Federal Governments pursuant to N.J.S.A. 30:4D-12.

4. Enroll individuals and provide services without reference to race, sex, age, religion, creed, color, national origin, ancestry or on the basis of health status or need for health services other than those services specifically excluded from coverage by the contract;

5. Comply with the requirement of having any contract resulting from a proposal be approved by the Health Care Financing Administration (HCFA) and the appropriate State control agencies before it shall become effective;

6. Have the organizational and administrative capabilities to carry out its duties and responsibilities under the contract, which shall include, at a minimum, the following:

i. A full time administrator to manage day-to-day business activities of the contractor and who is the responsible contract officer; this does not require a full time administrator to be dedicated solely to the Medicaid contract.

ii. Data reporting capabilities sufficient to provide necessary reports and to assure orderly and timely flow of reports to the Department;

iii. Financial records and books of accounts maintained in accordance with generally accepted accounting principles which are sufficient to disclose fully the disposition of all program funds received; and

iv. An annual independent audit arranged for by the contractor and which is performed by a certified public accountant;

7. Advise the Department of its administrative organization and changes thereto. This includes the functions and responsibilities of each principal, an organizational chart and list of all personnel and providers used either directly by the contractor or through subcontractural arrangements. For each principal and each provider, not previously reported, the following information shall be included:

i. Full name;

ii. Business address;

iii. Date of birth;

iv. Social Security Number;

v. IRS employer number;

vi. Professional license number (when applicable); and

vii. Medical specialty (when applicable);

8. Comply with eligibility requirements of the program which include, but are not limited to, for example, that the contractor shall only enroll individuals who are covered under specified Medicaid categories of assistance and who reside in the agreed upon market area;

9. Identify and provide financial disclosure of subcontractors with whom it has had business transactions in excess of $25,000 per year, and any significant business transactions with such subcontractors. Transactions that shall be reported include:

i. Any sale, exchange or leasing of property;

ii. Any furnishing for consideration of goods, services or facilities (but not employee salaries); and

iii. Any loans or extensions of credit;

10. Make available, upon request, any information reported to the State to the secretary of the Department of Health and Human Services, the Office of the Inspector General, the Comptroller General and to its enrollees. The State or Secretary may request that the information be in the form of a consolidated financial statement;

11. Disclose to the Division the identity of each person with a controlling interest or ownership of five percent or more; and

12. Not employ or contract with:

i. Any individual or entity excluded from Medicaid participation under sections 1128 or 1128A of the Social Security Act for the provision of health care, utilization review, medical social work, or administrative services; or

ii. Any entity for the provision of such services (directly or indirectly) through an excluded individual or entity.

(b) The contractor shall also comply with the Federal regulations governing HMOs or PHPs, as currently exist or hereinafter may be amended. The Federal regulations governing prepaid health care services may be found in the Code of Federal Regulations at 42 CFR 434 and 42 CFR 110.

10:49-10.3 Benefits

(a) The following concern the scope of benefits:

1. The Division shall be responsible for providing all noncovered HMO services that are Medicaid benefits to Medicaid enrollees. This means that any service or item normally provided under the New Jersey Medicaid Program shall be provided to enrollees if it is not covered under the terms of the contract with the HMO or PHP. The same limitations, such as prior authorization and medical necessity, are still applicable for Medicaid services provided outside the contract.

2. The benefits available under a nonrisk contract are those services and/or items that are specified in the contract.

3. The benefits available under a risk contract are those services and/or items that are specified in the contract.

4. Pursuant to Federal regulations (42 CFR 434.21), risk comprehensive contracts are risk contracts for furnishing comprehensive services, which shall include inpatient hospital services and any of the following services, or any three or more of the following services or groups of services:

i. Outpatient hospital services;

ii. Other laboratory and x-ray services;
iii. Covered long-term care services provided in nursing facilities, early and periodic screening, diagnosis and treatment (EPSDT), and family planning;
iv. Physicians' services;
v. Home Health services.
(b) The following concern the responsibilities of the contractor:
1. The contractor shall make available emergency services as defined in N.J.A.C. 10:49-10.1 on a 24-hour-a-day, seven-day-a-week basis.
2. The contractor shall offer health education services as an integral part of its health care delivery system to its enrollees in order to assure appropriate use of health care services and to promote the maintenance of health.
3. The contractor shall provide EPSDT equivalent services for all Medicaid enrollees under 21 years of age in accordance with the protocols approved by the Division. Initial physical examinations shall be provided. All further treatments indicated shall be provided in an appropriate and timely manner and shall be appropriately documented as specified by EPSDT requirements. The above shall be in accordance with EPDST regulations (42 C.F.R. 440.40(b); N.J.S.A. 30:4D-6a(4)b and N.J.A.C. 10:49-1.4(a)5.)
i. The Division shall monitor the EPSDT equivalent services through periodic audits.
4. The contractor shall provide or arrange to have provided all covered necessary health care services in a manner that is prompt, appropriate, and of a quality that conforms to generally acceptable professional standards as set forth in the Social Security Act, 42 U.S.C. 1302 et seq., and all other applicable Federal and State laws.
(c) The following service limitations in an HMO setting are consistent with those of the fee-for-service Medicaid program and are not included in the contractural service package or capitation payments even if provided by the HMO:
1. Services of podiatrists shall be provided with the exceptions of routine foot care and treatment of flat foot conditions, unless medical necessity determines otherwise.
2. Psychologists must be licensed and practice in the State of New Jersey.
3. Physical therapy, occupational therapy, and treatment for speech, language or hearing disorders are provided but limited to such services when provided to an enrollee by a nursing facility, by an approved home health agency, hospital outpatient department, independent outpatient clinic, or at contractor's facilities. Services provided by privately practicing therapists will not be eligible for payment under the capitation rate unless:
i. The physical therapist holds a current license to practice in New Jersey;
ii. The physical therapist is under contract with the contractor and will abide by the provisions of the contract; and
iii. The costs of these services are specifically identified in the contractor's proposed capitation rate.
4. Abortions are not covered under an HMO program but will continue to be paid on a fee-for-service basis by the Medicaid Program.
(d) The following are exclusions and are not covered services:
1. All claims arising directly or indirectly from services provided by or in institutions owned or operated by the Federal government;
2. Elective cosmetic surgery;
3. Rest cures and custodial or domiciliary care;
4. Personal comfort and convenience items; services and supplies not directly related to the care of the patient, including, but not limited to, guest meals and accommodations, telephone charges, travel expenses other than those services which may be specifically covered under the contract (such as ambulance services), take-home supplies and similar costs;
5. Services involving the use of equipment in facilities, the purchase, rental or construction of which has not been approved by applicable laws of the State of New Jersey and rules issued pursuant thereto;
6. All services not provided, approved or arranged by the HMO physician except in emergency situations as defined in N.J.A.C. 10:49-10.1;
7. Services provided in an inpatient psychiatric hospital that is not an acute care hospital to individuals under 65 years of age and over 21 years of age; and
8. Private duty nursing.
(e) The following concern the availability of services:
1. Each contractor shall demonstrate the availability and accessibility of sufficient numbers of institutional facilities and professional, allied and supporting paramedical personnel to perform adequately the agreed-upon services.
2. Each contractor shall insure that no distinctions will be made with regard to quality of service or availability of benefits between Medicaid enrollees under this subchapter and any other parties served by the contractor.
3. To the extent feasible and appropriate, each Medicaid enrollee shall be given the choice of a primary care physician who will supervise and coordinate his or her care.
4. Generally, the contractor must have only one market area for all Medicaid parties served, including those served under this subchapter. Modifications of such market area for purposes of contracting under this subchapter shall be subject to approval by the Division.

10:49-10.4 Marketing and enrollment
(a) The following concern marketing by the contractor:
1. The contractor shall obtain written approval from the Division prior to implementing the following:
i. The form and content of informational and instructional materials to be distributed to Medicaid enrollees, outlining the scope and nature of benefits provided by the contractor;
ii. The form and content of informational and instructional materials to be distributed to inform Medicaid enrollees of changes in program scope or administration; and
iii. The form and content of all public information releases pertaining to the enrollment of Medicaid individuals in the contractor's plan.
2. The contractor shall insure that:
i. All marketing presentations accurately and clearly represent the benefits and limitations of the contractor's plan;
ii. The marketing representatives have received sufficient instructions and training to be capable of performing such marketing activities;
iii. The marketing representatives shall only represent themselves as agents of the contractor involved in marketing;
iv. All marketing presentations make clear that HMO enrollment is voluntary; and
v. The marketing representatives are prohibited from offering or giving any form of compensation or reward as an inducement to a Medicaid recipient to enroll in the contractor's plan.
(b) The following concern information to members:
1. At such time as a Medicaid recipient signs an enrollment application of an HMO or prepaid health plan, the contractor shall inform the eligible that:
i. There is normally a minimum 30 to 45-day processing period between the date of application and the effective date of enrollment;
ii. During this interim period, the Medicaid enrollee may continue to receive health care services under his or her current arrangement as long as he or she retains Medicaid eligibility; and
iii. Subject to the disenrollment provisions specified in (d) below and the termination provisions in the contract between the contractor and the Department, enrollment is for a period of six months at a time.
2. Within 10 days after the effective date of coverage, or as specified in the contract, the contractor shall provide in writing to a new enrollee:
i. Notification of his or her effective date of enrollment;
ii. An identification card clearly indicating that the bearer is an enrollee in the HMO or prepaid health plan;

iii. Specific written details on benefits, limitations, exclusions, and availability and location of services and facilities. Thereafter, such notification shall be provided at least annually;

iv. An explanation of the procedure for obtaining benefits including the address and telephone number of primary care physicians, the hours and days facilities are open, and accepted appointment procedures;

v. Information regarding continued enrollment in the contractor's plan including patient's rights and patient's responsibilities, and the reasons a person may lose eligibility for the plan and what should be done if this occurs;

vi. Procedures for resolving complaints;

vii. Information giving reasons and procedures for disenrollment;

viii. Any other information essential to the proper use of the plan as may be required by the Division;

ix. An explanation of where and how 24-hour-a-day emergency medical care and out-of-area coverage is available; and

x. An explanation of how to obtain non-covered HMO services that are Medicaid benefits.

3. Information as required by (b)2 above shall be supplied whenever there are significant changes in the services provided or the locations where they can be obtained, or other changes in program nature and administration. Such information shall be provided to each enrolled family household at least 10 days prior to such change.

(c) The following concern enrollment:

1. The contractor shall enroll Medicaid recipients in the order in which they apply, without restrictions, up to contract limits.

2. Enrollment shall be accomplished by the individual's voluntary signing of an enrollment application agreeing to utilize only the health care services provided or arranged by the contractor.

3. Enrollment shall be for the entire Medicaid case (family household). The contractor shall not enroll a partial case except at the Director's discretion.

4. Enrollment shall be for periods of six months and in accordance with Federal statute, Section 1903(m)(2)(F) of the Social Security Act with the exceptions indicated in (d) below. This fact shall be clearly stated on the enrollment application.

5. At any time during the first 30 days of each six-month enrollment period, the enrollee may elect to disenroll from the contractor's plan, upon written notification to the contractor, without stating a cause and with cause thereafter. The contractor may terminate an enrollee's enrollment for reasonable cause through a grievance process which is consistent with applicable State and Federal regulations and is approved by the Division.

6. The contractor shall obtain written approval from the Director prior to implementing a method of enrollment and enrollment forms to be used to enroll Medicaid recipients.

7. For any person who applies for participation in the plan and who is hospitalized at the time this coverage would become effective, such coverage shall not commence until the date such person is discharged from the hospital.

(d) The following concern disenrollment:

1. Disenrollment of an enrollee from the plan will occur:

i. Whenever the enrollee is no longer qualified to receive Medicaid services, unless otherwise specified in the contract;

ii. Whenever the enrollee moves outside of the market area boundaries;

iii. Whenever the contract between the Department and the contractor is terminated; or

iv. Through formal grievance.

2. Provision shall also be made for an enrollee's voluntary disenrollment from the contractor's plan in accordance with Section 1903(m)(2)(F) of the Social Security Act.

3. Until such time as the enrollee's termination of coverage becomes effective, the contractor shall remain liable for all contracted services. If an enrollee is hospitalized at the time of disenrollment or termination, the contractor shall be liable for all inpatient hospital charges (if a contracted service).

10:49-10.5 Medical records; peer review; quality assurance

(a) The following concern medical records:

1. Each contractor shall maintain a medical record on each enrollee who has received medical services while enrolled in the contractor's plan.

2. Each enrollee's medical records shall be kept in detail consistent with Federal and State requirements and good medical and professional practice based on the service provided. Furthermore, each contractor shall conform to the standards of confidentiality of information mandated for Federal and State officials (Section 1902(a)(7) of the Social Security Act, 42 CFR 431.300, N.J.S.A. 30:4D-7(g) and N.J.A.C. 10:49-1.22).

3. Medical records of enrollees shall be sufficiently complete to permit subsequent peer review or medical audit. All required records, either originals or reproductions thereof, shall be maintained in legible form and readily available to appropriate Division professional staff upon request for review and evaluation by professional medical and nursing staff.

4. The contractor shall release medical records of enrollees, as may be directed by authorized personnel of the Division, appropriate agencies of the State of New Jersey or the U.S. Government and shall be consistent with the provisions of confidentiality (Section 1902(a)(7) of the Social Security Act, 42 CFR 431.300 N.J.S.A. 30:4D-7(g) and N.J.A.C. 10:49-1.22).

5. All records shall be retained in accordance with the record retention requirements of 45 CFR Part 74 and appropriate State law.

6. The Division has the right to conduct audits according to appropriate Federal and State statutes and regulations.

(b) The following concern peer review:

1. Each contractor shall submit a description of its system of internal peer review to the Division for approval to assure the acceptable professional practice shall be followed by the contractor as well as its subcontractors.

2. There shall be an explanation of how such peer review procedures will relate to the applicable Peer Review Organization (PRO) or other utilization review organization should such exist.

3. The number of cases reviewed and summaries of the actions taken by the peer review system shall be reported annually to the Division.

(c) Quality assurance rules require that:

1. The Division and the Department of Health and Human Services shall have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract in accordance with State (N.J.S.A. 30:4D-7s) and Federal (42 CFR 434-34) requirements.

2. The contractor shall offer assurances that all health care services required by each enrollee shall meet quality standards within the acceptable medical practice of care consistent with the medical community standards of care.

3. The contractor shall submit a detailed plan for establishing and maintaining an internal quality assurance system to the Division for approval to assure that acceptable professional practice will be followed by the organization and its subcontractors. This shall include a proposed system for continuing performance review and health care evaluation, that is, an explanation of the methods which the contractor proposes to follow in guaranteeing that the services provided each enrollee will meet criteria required by appropriate Federal regulations (42 CFR 434.34).

4. The contractor shall agree to medical audits relating to its standard of medical practice and the quality, appropriateness and timeliness of health care services provided all enrollees, as may be required by the Division. The medical audit shall include, at a minimum, the review of:

i. The delivery system for patient care;

ii. Utilization data and medical evaluation of care provided and patient outcomes for specific enrollees as well as for a statistical representative sample of enrollee records;

iii. The peer review system and reports; and

iv. The grievances relating to medical care including their disposition.

5. The results of the medical audits may be disclosed to the public on a need-to-know basis by the State, consistent with State and Federal law.

6. The contractor shall agree to release the comprehensive medical records of enrollees upon termination of their coverage, as may be directed by the enrollee, authorized personnel of the Division, appropriate agencies of the State of New Jersey, or the United States Government.

10:49-10.6 Grievance procedure

(a) The contractor shall establish a grievance procedure for the receipt and adjudication of any and all complaints from enrollees relating to quality, scope, nature and delivery of services. Such grievance procedures shall be communicated to the enrollee in writing to provide for expeditious resolution of grievances by the contractor's personnel at a decision-making level with authority to require corrective action. The contractor shall also review the complaint procedure at reasonable intervals, but no less than annually, for the purpose of amending same, with the prior written approval of the Division in order to improve said system and procedure.

(b) The contractor shall insure that all enrollees receiving services funded under Title XIX of the Social Security Act shall be informed in a simple, brief statement of their rights to a fair hearing (10:49-5.1) and of the contractor's grievance review procedures. This may be accomplished by an annual mailing, a member handbook, or any other method approved by the Division.

(c) The contractor shall report all completed grievances to the Division with a brief statement of the problem and resulting outcome on a quarterly basis.

10:49-10.7 Financial arrangements

(a) The contractor shall submit for Division approval information in sufficient detail to describe:

1. The exact capitation rate requested for each category of medical assistance covered under the contract;

2. The major cost components that constitute each capitation rate, including at a minimum the projected costs of hospital services, physician services, administration, and other components as approved by the Division; and

3. A detailed description of the underlying assumptions and procedures followed by the contractor in determining its rate.

(b) The annual capitation rate for any contractor may not exceed the expected per capita, fee-for-service cost for similar services provided to an actuarially equivalent non-enrolled population who reside in the contractor's market area.

(c) Capitation rates shall be subject to negotiation before the contract renewal, but shall not be revised more often than annually.

(d) Any capitation rate paid to the contractor shall not include payment for recoupment of losses incurred by the contractor from prior years.

(e) A stop loss provision may be made available for risk contracts as determined appropriate by the Division, the amount of which would be specified in the contract.

(f) The contractor is responsible for payment of all contracted covered services, including emergency services as defined in the contract, rendered to an enrollee whether or not such services are provided at the contractor's facilities.

(g) The contractor shall make available to the Division for inspection and audit any financial records of the contractor or its subcontractors in accordance with 42 CFR 434.38.

(h) If third party liability exists for an enrollee, for example, by health insurance contract, subrogation or tort, the Division shall require the contractor to recover, or attempt to recover, all appropriate payments from any and all liable third party sources for services rendered to enrollees. Likewise, the Division shall require that the contractor use its best efforts to insure that its subcontractors utilize these same payment sources.

1. It is the contractor's responsibility to recover monies from liable third parties and any monies so recovered are the property of the contractor.

2. The contractor shall include in its periodic reporting to the Division a complete disclosure demonstrating its efforts to obtain payment from liable third parties and of the amount and nature of third party payments recovered for Title XIX enrollees, including, but not limited to, services and conditions which are:

i. Employment-related injuries or illnesses;

ii. Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers or bicyclists; and

iii. Contained in Diagnosis Codes 800 through 999 (ICD-9-CM) with the exception of Code 994.6 (see International Classification of Diseases. 9th ed.).

3. The Division will thereafter pursue a policy of deducting an amount actuarially determined to be representative of the availability of third party coverage from the capitation rate, unless the capitation rate already includes an allowance for the recovery of third party payments.

10:49-10.8 Capitation payments to contractors

(a) For Medicaid enrollees enrolled in accordance with N.J.A.C. 10:49-10.4(c)2, the Division will pay the capitation rate no later than the 15th day of the month in which that individual will be eligible to receive services.

(b) The Division shall make monthly payments to the contractor based upon the total number of certified enrollees and negotiated capitation rate(s).

10:49-10.9 General reporting requirements

(a) Each contractor shall furnish such timely information and reports as the Division may find necessary or may require. Such reports shall include information sufficient for Division management and evaluation purposes in at least the following areas:

1. Marketing and enrollment performance;

2. Enrollee identification data, such as age, sex, and residence;

3. Utilization data for covered services provided under the contract;

4. Financial data; and

5. Third-party payment recoveries for enrollees.

(b) The contractor shall submit to the Division at least annually information specified by the Division on non-Medicaid enrollees for purposes of comparative analyses of services use and cost patterns.

(c) Each contractor shall maintain records in accordance with 45 CFR 74 and make available to authorized personnel of the Division all records created pursuant to the contracts entered into under this subchapter.

(d) All significant changes that may affect the contractor's performance under the contract shall be immediately reported to the Division.

(e) The contractor, with the prior written approval of the Division as to form and content, shall arrange for the distribution of informational materials to all subcontractors providing services to enrollees, outlining the nature, scope and contract requirements.

10:49-10.10 Contract sanctions

(a) If the Division finds that a contractor fails to comply with any of the appropriate laws, regulations or terms of the contract, or for other good cause, the Division may impose one or all of the following:

1. A letter of admonishment to the contractor indicating that continued violations may lead to the imposition of sanctions listed in (a)2, 3 or 4 below;

2. A suspension of further enrollments and one or more marketing activities;

3. A withholding of all or part of the capitation payments; and/or

4. Termination of the contract.

(b) The Division shall give reasonable written notice of its intention to impose sanctions to the contractor, and, if necessary as determined by the Division, to enrollees and others who may be directly interested. Such written notice shall state the effective date of, and the reason for, the sanctions.

(c) The contractor or Division shall have the right to terminate the contract with at least 90 days' written notice to the other party, or as otherwise stated in the contract.

(d) Pursuant to Section 1903(m)(5)(A) of the Social Security Act, codified as 42 U.S.C. 1396b, the Secretary of the Department of

Health and Human Services may impose substantial civil money penalties on the contractor if:

1. It has failed to substantially provide required medically necessary items and services if that failure has adversely affected the enrollees or has substantial likelihood of adversely affecting the enrollees;

2. It imposes premiums on enrollees in excess of the premiums allowed by law;

3. It discriminates among enrollees on the basis of their health status or requirements for health care services by expulsion or refusal to re-enroll an enrollee or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment by eligible persons whose medical condition or history indicates a need for substantial future medical services; or

4. It misrepresents or falsifies information that is furnished to (a) the Secretary or the State or (b) to any person or to any other entity under this subsection.

(e) The Secretary may provide, in addition to any other remedies available under law, for any of the following remedies:

1. Civil money penalties of not more than $25,000 for each determination under (d) above, or, with respect to a determination under (d)3 or (d)4a above, of not more than $100,000 for each such determination, plus, with respect to a determination under (d)2 above, double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and, plus, with respect to a determination under (d)3 above, $15,000 for each individual not enrolled as a result of a practice described in such paragraph.

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Manual of Requirements for Child Care Centers Licensing Fees

Proposed Amendments: N.J.A.C. 10:122-2.1 and 2.8

Authorized By: Alan J. Gibbs, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:5B-1 to 15 and 18A:70-1 et seq.

Proposal Number: PRN 1992-26.

Submit comments in writing by February 5, 1992 to:

Richard Crane, Acting Chief
Bureau of Licensing
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Division of Youth and Family Services in the Department of Human Services is authorized to license child care centers in New Jersey pursuant to N.J.S.A. 30:5B-1 to 15. Also, the Division is authorized to issue a physical facility and life/safety approval to centers that were operating prior to May 16, 1984 by an aid society of a properly organized and accredited church under N.J.S.A. 18A:70-1 et seq. Under N.J.S.A. 30:5B-8, the Department is authorized to establish licensing fees.

The Division of Youth and Family Services' Bureau of Licensing proposes to increase the fees for a license to operate a child care center and to increase the fee for a Certificate of Life/Safety Approval, which is issued to certain church-operated centers that were operating and exempt from licensure prior to the passage of the Child Care Center Licensing Law in 1984. In order to reflect these fee changes, amendments are being proposed to N.J.A.C. 122, the Manual of Requirements for Child Care Centers. These proposed amendments seek to revise the licensing fees that were last set in 1974 and that have not been adjusted for inflation or to account for increased costs in licensing services over the past 17 years. The Division recently conducted an analysis of the rise in the Consumer Price Index (generally recognized as a major indicator of inflation) which revealed an increase for New Jersey of some 178 percent since 1974. The increases in fees being proposed by the Division, are, however, considerably lower than that rate of inflation, recognizing that an increase in the licensing fees all at once at the inflationary level could have a significant economic impact on many licensed centers and would represent an unreasonable rise in the fees charged to these programs. The proposed fee increases are necessary to help the State offset the increased costs it has incurred in licensing and inspecting these centers and in providing technical assistance and other essential licensing-related services. These revised fees will be charged for new centers as well as for existing centers renewing their licenses. Centers currently pay $75.00 for a three-year license.

For the first time, however, the Division plans to institute a system of differential fees for licensed centers keyed to the licensing capacity (maximum number of children the center can serve), rather than charging a single uniform fee for all licensed centers as it does currently.

The system is designed to provide a fairer and more equitable fee schedule that charges the highest fees for the largest capacity centers and the lowest fees for centers with the smallest capacity, with gradations in between. Specifically, five different cohorts of center size have been established: the lowest fees—$100.00 for a three-year license—would be charged to centers in the smallest cohort (serving six to 15 children), with the fees rising in increments of $25.00 across the larger cohorts. Centers in the largest cohort (serving over 100 children) would pay the highest three-year fee—$200.00. This new system of assessing fees by capacity ensures that smaller centers will not be unduly burdened by the rise in fees, since they would pay a lower fee proportional to their fiscal resources. In particular, the small "mom and pop" child care centers realize only a marginal increase in fees ($25.00 for a three-year license). Thus, development of new small center-based resources would not be discouraged. Larger centers, which realize the highest revenues through more tuition fees, would pay a fee more proportional to those resources than the current $75.00 fee. Thus, even if these centers pass the costs onto consumers directly, the amount would not be burdensome. The fee, when broken down to an annualized cost, would come to no more than $1.00 to $2.00 per child per year, depending upon the size of the center.

The fee to secure a Certificate of Life/Safety Approval for certain church-operated centers will remain as a flat fee and not be determined by the capacity of the center. A flat fee of $100.00 for a three-year Certificate of Approval will be charged for this category of center; the current flat fee is $50.00 for a three-year Certificate of Approval. It was reasoned that since these centers only receive life/safety inspections from the Division, a fixed fee (rather than a sliding fee scale) would be preferable. Also, a single flat licensing fee of $100.00 will be assessed to the approximately 15 licensed centers statewide that operate for only short durations, that is, eight weeks or less each year. These centers generally only provide services to children during the summer months. The fixed fee will be charged to these centers regardless of capacity, since these seasonally operated centers require and receive fewer services from the Division as a result of their short programs. Finally, a single flat licensing fee of $100.00 will be assessed to the Head Start centers as well, regardless of their capacity. These centers, which provide a specialized program of services to children from disadvantaged and impoverished families, do not charge a fee to the families they serve, and, thus, cannot pass the additional costs of the licensing fee on to the consumers.

These proposed amendments to increase licensing fees for child care center licenses and Certificates of Life/Safety Approval for church-operated child care centers were shared and discussed with all the major child care organizations through a series of meetings with representatives from the Division's Bureau of Licensing for the purpose of securing their feedback and recommendations. The organizations included: the Child Care Advisory Council (CCAC), including the Council's Legislative and Government Action Committees; Coalition of Infant/Toddler Educators (CITE); New Jersey Association for the Education of Young Children (NJAEYC); New Jersey Child Care Association (NJCCA); New Jersey Statewide Coalition for Child Care; New Jersey Recreation and Park Association (NJRPA); New Jersey Statewide Head Start Directors Association; and the DYFS Day Care Policy Development Board (PDB). While these groups expressed misgivings about whether the fees might result in increased costs to centers, they generally understood and accepted the reasons for the increases and the Division's need to raise revenues through higher fees. It should be pointed out that this fee proposal actually represents a revision of an initial fee increase proposal that was developed and shared earlier this year with these constituent organizations and which sought to generate an additional $200,000 in new revenues. As such, the original proposed fee increases were substan-

tially higher than those reflected in the current proposal and would have called for increases ranging from $150.00 to $600.00 for a three-year license—an average increase of about 200 percent over the current $75 fee. That plan was met with a good deal of concern from the leadership of the major child care organizations in the State, who felt that the magnitude of the fee increases would have a severe economic impact on many centers. In response, the Division revised the new revenue target downward to $50,000 per year that would be generated by the increase in licensing fees and shared the revised proposal with the child care community. As a result, these child care organizations/groups, which represent many of the State's licensed centers, have expressed acceptance of and support for this current fee increase proposal.

The first amendment at N.J.A.C. 10:122-2.1(c) repeals the existing triennial $75.00 licensing fee for all licensed child care centers and creates a system of differential licensing fees based on the licensing capacity of licensed centers.

The second proposed amendment at N.J.A.C. 10:122-2.1(d) establishes a flat licensing fee of $100.00 for a three-year licensing cycle for centers that operate eight weeks or less each year.

The third proposed amendment at N.J.A.C. 10:122-2.1(e) establishes a flat licensing fee of $100.00 for a three-year licensing cycle for Head Start child care centers.

The fourth proposed amendment at N.J.A.C. 10:122-2.8(b) eliminates the existing triennial $50.00 fee for a Certificate of Life/Safety Approval and establishes a flat fee of $100.00 for a three-year approval cycle for church-operated centers that fall in this category. These constitute some 119 Life/Safety-approved church-operated child care centers that receive only life/safety inspections as provided for in the Child Care Center Licensing Law. It is unlikely that the universe of Life/Safety-approved centers will increase in numbers, since these centers were grandfathered with the passage of the law in 1984.

Social Impact

These proposed amendments to seek to adjust and update the fees charged for child care center licenses and Certificates of Life/Safety Approval so that the fees help offset to a greater extent the costs to the Division of Youth and Family Services in processing and issuing child care center licenses and Certificates of Life/Safety Approval and in regulating these facilities. During the past seventeen years the Consumer Price Index for New Jersey has risen approximately 178 percent. While the proposed fee increases are an attempt to adjust to this increase, in actuality the average proposed fee increases amount to much less than the 178 percent increase in the Consumer Price Index. The Division provides programmatic and life/safety inspections for some 2,200 child care centers in New Jersey, a range of vitally needed regulatory services, including: a number of technical assistance services to these centers on licensing-related matters, complaint investigations, free courtesy inspections, architectural plan reviews for prospective new centers, and training in licensing-related issues for center directors and staff. These inspections and services help to ensure the health, safety and well-being of the children placed in these centers. The issuance of licenses and Certificates of Life/Safety Approval to centers that achieve compliance with the Manual of Requirements for Child Care Centers helps to assure parents and the community that these centers are reliable and safe resources for children. Thus, the social impact of these amendments is a positive one to the extent that it can help the State absorb the increasing costs of providing these licensing services.

Economic Impact

The Division does not anticipate a significant negative economic impact as a result of these amendments on the 2,200 licensed or approved child care centers regulated by the Division. While some centers may have misgivings about whether the fees might result in increased costs to them, the Division's licensing constituents for the most part understood and accepted the reasons for the increases and the Division's need to raise revenues through higher fees. The Division's proposed fee increases are considerably below the rate of inflation that has occurred since 1974, when the licensing fees were last adjusted (approximately 178 percent according to the Consumer Price Index for New Jersey.)

Further, the Division is proposing for the first time, a fairer and more equitable fee assessment schedule. The proposed fees are set up in a differential fee schedule according to the licensing capacity of the center, so that the costs are more proportional to the center's revenues, and have the smallest impact on the smaller centers. The Division anticipates that the additional cost to parent-consumers would be minimal if centers pass the costs on to them, amounting to about one to two dollars a year per child, depending on center size.

The economic impact on the Division will be positive, since these new fees will generate additional revenues to the State and help offset the rising costs for conducting inspections, processing licenses and Certificates of Life/Safety Approval and providing a wide range of related licensing services.

Regulatory Flexibility Analysis

These proposed amendments will affect some 2,200 licensed/approved child care centers, most of which fall within the definition of a small business, as defined in the State Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. By establishing a range of fees based on the center's capacity, the Division aims to diminish the economic impact on the smallest of the small businesses. These proposed amendments do not impact on the center's reporting, recordkeeping or other compliance requirements that centers must meet. These amendments seek only to establish revised fees for licenses issued to licensed child care centers and church-operated Life/Safety-approved centers.

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

10:122-2.1 Applications for a license

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

(c) An applicant for an initial or renewal license shall submit with the completed application form [a $75.00] **the specified** licensing fee[,] **listed in the chart below**, in the form of a check or money order made payable to the "Treasurer, State of New Jersey."

LICENSING FEES FOR CENTERS

Center's Licensed Capacity	**Three Year Fee**
6-15	**$100.00**
16-30	**125.00**
31-60	**150.00**
61-100	**185.00**
101 and up	**200.00**

(d) In lieu of the fees specified in (c) above, an applicant for an initial or renewal license who operates a center for eight weeks or less each year shall submit with the completed application form a $100.00 licensing fee, in the form of a check or money order made payable to the "Treasurer, State of New Jersey."

(e) In lieu of the fees specified in (c) above, an applicant for an initial or renewal license who operates a Head Start center, pursuant to, 42 U.S.C. 9831 et seq., shall submit with the completed application form a $100.00 licensing fee, in the form of a check or money order made payable to the "Treasurer, State of New Jersey".

[1.]**(f)** If the application is denied, or the center does not open, the Bureau will [upon request,] refund the licensing fee to the applicant.

[2.]**(g)** The licensing fee will not be refunded once the Bureau issues the center a license.

10:122-2.8 Procedures for securing a Certificate of Life/Safety Approval for centers operated by an aid society of a properly organized and accredited church prior to May 16, 1984, pursuant to N.J.S.A. 18A:70-1 to 9

(a) (No change.)

(b) The applicant shall submit to the Bureau a [$50.00] **$100.00** fee in the form of a check or money order made payable to the "Treasurer, State of New Jersey," along with the completed application of a Certificate of Life/Safety Approval.

(c) (No change.)

LABOR

(a)

DIVISION OF WORKPLACE STANDARDS

Safety and Health Standards for Public Employees General Standards and Standards for Firefighters

Proposed Amendments: N.J.A.C. 12:100-4.2, 17.1 and 17.3

Proposed New Rules: N.J.A.C. 12:100-10

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor

Authority: N.J.S.A. 34:20-1, 34:1A-3(e); and 34:6A-25 et seq., specifically 34:6A-30, 31 and 32.

Proposal Number: PRN 1992-22.

A **public hearing** on this proposal will be held on:
Monday, January 27, 1992 at 6:00 P.M. at
Richard J. Hughes Justice Complex
4th floor
CN 054
Trenton, New Jersey

Submit written comments by March 7, 1992 to:
Linda Flores
Special Assistant for External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

The New Jersey Public Employees Occupational Safety and Health Act (PEOSHA), N.J.S.A. 34:6A-25 et seq., effective on January 17, 1984, was enacted to ensure that all public employees are provided with safe and healthful work environments free from recognized hazards.

On November 5, 1984, the New Jersey Department of Labor (DOL) adopted by reference the existing Federal Occupational Safety and Health Standards which included general industry standards, construction standards and agricultural standards (see 16 N.J.R. 3051(a)).

Among the General Industry Standards adopted at N.J.A.C. 12:100-4 was Subpart L, Fire protection of 29 CFR Part 1910. In section 1910.156 at Subpart L, the Federal Standard addresses requirements for personal protective clothing, personal equipment, and respiratory protection devices for firefighters. In 1980, the New Jersey Department of Health undertook a major study of the hazards faced by firefighters in the State. The subsequent report, "Firefighting in New Jersey: Hazards and Methods of Control," included recommendations which incorporated and which often went beyond the Federal Occupational Safety and Health Administration (OSHA) standards.

In June of 1987, an amendment to N.J.A.C. 12:100-4.2(a)9 (since recodified as paragraph (a)10) was adopted which established that personal protective clothing ordered or purchased after November 6, 1986 had to comply with the OSHA standards. Further, this amendment established that after November 6, 1988 the employer had to assure that all firefighters wear the personal protective clothing as required by the OSHA standards.

At the present time, there is renewed interest in upgrading the standards for firefighters to ensure that the best protection for firefighters is made available. These proposed amendments are derived, for the most part, from current standards of the National Fire Protection Association (NFPA) and are more stringent than current OSHA standards. The NFPA standards from which these rules were derived have also been adopted as American National Standards by the American National Standards Institute (ANSI). On April 9, 1991, the Public Employees Occupational Safety and Health Advisory Board held its regular meeting. Pursuant to that meeting the Department of Labor, in consultation with the Department of Health (DOH), the Department of Community Affairs (DCA) and with the advice and consent of the Public Employees Occupational Safety and Health Advisory Board, is proposing to adopt by reference the above amendments, with modifications, as set forth below to replace the OSHA Standards 1910.156 of Subpart L of 29 CFR part 1910, covering protective clothing, personal equipment and respiratory protection devices for firefighters.

The proposed amendments include the following standards. It should be noted that in standards identified by two numbers, the first refers to the standard and the second to the year it was adopted. In addition, the NFPA titles use of "fire fighter" has been corrected to "firefighter" throughout this proposal.

1. NFPA No. 1971, Standard on Protective Clothing for Structural Firefighting, used in formation of the OSHA Fire Protection Standard for turnout coats and bunker pants, is more protective than the current OSHA standard;

2. NFPA No. 1973, Standard on Gloves for Structural Firefighters, published after the promulgation of the OSHA Fire Protection Standards, contains improved performance requirements for sizing, dexterity and resistance to water penetration;

3. NFPA No. 1972, Standard on Structural Firefighters' Helmets, is more stringent than the OSHA standard because it requires the helmet to pass a higher radiant heat load impact test. Incidents have been documented throughout the country where helmets meeting OSHA standards have been unable to withstand exposure to heat conditions encountered by firefighters performing interior structural firefighting;

4. NFPA No. 1974, Standard on Protective Footwear for Structural Firefighting, is the first edition of this standard. It was published in 1987 and has been approved by the American National Standards Institute;

5. NFPA No. 1975, Standard on Station/Work Uniforms for Firefighters, establishing criteria for a station/work uniform which, when worn under protective clothing, will not contribute to firefighter injury nor cause any degradation of the performance features of the firefighter protective clothing, will eliminate the use of fabrics such as those polyesters which melt under heat and will allow the use of a natural fabric such as cotton, as well as certain synthetics, textiles and other materials;

6. NFPA No. 1981, Standard on Self-Contained Breathing Apparatus, provides standard requirements for the use of specific types of self contained breathing apparatus for firefighters exposed to hazardous atmospheres;

7. NFPA No. 1982, Standard of Personal Alert Safety Systems (PASS) for Firefighters, provides personal alert safety systems worn by firefighters that will emit an audible alarm signal to summon aid in the event the firefighter becomes incapacitated or needs assistance;

8. NFPA No. 1983, Standard of Fire Service Life-Safety Rope, Harnesses, and Hardware, provides a reasonable degree of safety for life-safety rope, harnesses and hardware used to support fire services personnel and civilians during rescue, firefighting, and other emergency operations, or during training evolutions;

9. ANSI Z88.5-1981, Practices for Respiratory Protection for the Fire Service, which is more complete than the OSHA standard, describes how to achieve the objectives of a respiratory protection program and mandates the use of self-contained breathing apparatus during overhaul;

10. NFPA No. 1901—1991, Standard for Pumper Fire Apparatus, includes new requirements to improve the safety of persons using this apparatus, by specifying the total enclosure of all crew seating areas and requiring that seatbelts be provided;

11. NFPA No. 1902—1991, Standard for Initial Attack Fire Apparatus includes new requirements to improve the safety of the persons using this apparatus. This standard specifies the total enclosure of all crew seating areas and requires that seatbelts be provided;

12. NFPA No. 1903—1991, Standard for Mobile Water Supply Fire Apparatus includes new requirements to improve the safety of the persons using this apparatus. This standard specifies the total enclosure of all crew seating areas and requires that seatbelts be provided; and

13. NFPA No. 1904—1991, Standard for Aerial Ladder and Elevating Platform Fire Apparatus includes new requirements to improve the safety of the persons using this apparatus. This standard specifies the total enclosure of all crew seating areas and requires that seatbelts be provided.

The proposed amendment to N.J.A.C. 12:100-4.2, with certain changes, adopts by reference the General Industry Standards from 29 CFR Part 1910 relating to fire protection. The amendment to N.J.A.C. 12:100-4.2(a), which provides that 29 CFR 1910.155(a) and 1910.156 are not adopted is necessary due to the Department's decision to require, instead, compliance with the more stringent National Fire Protection Association's standards.

The proposed new subchapter at N.J.A.C. 12:100-10 sets forth safety standards for firefighters.

1. N.J.A.C. 12:100-10.1 sets forth the scope of the subchapter, and N.J.A.C. 12:100-10.2 is a definitions section;

2. N.J.A.C. 12:100-10.3 requires that each employer have a policy which contains the organizational structure of the fire service, its number of members and its functions;

3. N.J.A.C. 12:100-10.4 sets forth the parameters which must be adhered to by prospective employees;

4. N.J.A.C. 12:100-10.5 states that the employer must provide to employees protective clothing at no cost to the employee;

5. N.J.A.C. 12:100-10.6 addresses the requirements for foot and leg protection;

6. N.J.A.C. 12:100-10.7 addresses body protection;

7. N.J.A.C. 12:100-10.8 addresses hand protection;

8. N.J.A.C. 12:100-10.9 concerns head, eye and face protection;

9. N.J.A.C. 12:100-10.10 requires employers to provide, at no cost to employees, respiratory protection devices. This section sets forth the uses of various apparatus that are acceptable and states the conditions under which such apparatus should be used;

10. N.J.A.C. 12:100-10.11 requires employers to furnish necessary life-safety rope, harnesses and hardware to employees;

11. N.J.A.C. 12:100-10.12 requires employers to provide employees with a personal alert safety system;

12. N.J.A.C. 12:100-10.13 addresses the requirements for hearing protection. Hearing protection during emergency situations is still under study, and rules will be issued at a later date;

13. N.J.A.C. 12:100-10.14 addresses the procedure for filling air cylinders;

14. N.J.A.C. 12:100-10.15 sets forth guidelines for fire apparatus operations; and

15. N.J.A.C. 12:100-16 sets forth the inspection schedule for maintenance of firefighter equipment.

The proposed amendments to N.J.A.C. 12:100-17.1 update the list of standards and publications referred to in the chapter.

Social Impact

In comparison with other occupations, firefighting is one of the most hazardous occupations, since firefighting fatalities, injury and illness rates are very high. Therefore, it is important to outfit firefighters with proper personal protective clothing, personal equipment and respiratory protection devices to insure their health and safety. Inasmuch as firefighters risk their lives to serve the public, the public must make a commitment to provide them with proper protective equipment. Implementation of the proposed new rules and amendments is intended to reduce instances of death, injury and illness associated with firefighting. The proposed new rules and amendments will also help firefighters perform their jobs more effectively. Moreover, the Department of Labor (DOL), Department of Community Affairs (DCA), and the Department of Health (DOH), will be available to provide technical assistance in the implementation of these rules and amendments.

Economic Impact

The cost of implementing the proposed rules and amendments is expected to result in less absenteeism, greater adherence to work schedules, decreased medical expenses, and decreased worker compensation, disability, and social security expenses. The various municipalities and volunteer fire companies will incur increased costs associated with purchasing the upgraded firefighting equipment. Additionally, by providing firefighters with this equipment, individuals who could not previously afford to become firefighters may now be able to contribute their services in the public interest.

Regulatory Flexibility Statement

Municipal fire departments, as branches of local governments, are not small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The Department of Labor does not believe that volunteer fire companies are small businesses as defined under that Act. However, the following regulatory flexibility analysis is appropriate in the event they are considered small businesses:

Volunteer fire companies are required to comply with the provisions of these rules regarding their firefighting protective equipment, incurring the attendant costs. The proposed rules will not impose any additional reporting or recordkeeping requirements on volunteer fire companies. In addition, no professional services will need to be employed to meet the new standards. These rules are necessary for the safety of firefighters in the performance of their duties; therefore, lesser standards or exemptions from the standards cannot be provided to volunteer fire companies. However, it should be noted that while compliance with the foot and leg protection and body protection requirements of these rules is required within two years of this effective date for the career fire service, compliance for the volunteer fire service is necessary when replacement of existing foot and leg protection and body protection, respectively, is required.

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

12:100-4.2 Adoption by reference

(a) The standards contained in 29 CFR Part 1910, General Industry Standards, with the amendments published in the Federal Register through March 6, 1989 with certain exceptions noted in (b) and (c) below are adopted as occupational safety and health standards and shall include:

1.-9. (No change).

10. Subpart L—Fire Protection except that[;]:

[i. 29 CFR Part 1910.156(e)(l)(i) is amended to read: The employer shall assure that protective clothing ordered or purchased after November 6, 1986, complies with paragraph (e). As the new protective clothing is provided, the employer shall assure that all fire brigade members wear the protective clothing when performing interior structural firefighting. After November 6, 1988, the employer shall assure that all fire brigade members wear protective clothing meeting the requirements of paragraph (e) when performing interior structural firefighting. All personal protective clothing required to be provided to members of a fire brigade pursuant to paragraph (e) shall be provided at no cost to the employee.]

i. Paragraph 1910.155(a) and Section 1910.156 are not adopted.

11.-19. (No change.)

(b) and (c) (No change.)

SUBCHAPTER 10. [(RESERVED)] STANDARDS FOR FIREFIGHTERS

12:100-10.1 Scope; standards information

(a) This subchapter shall apply to all public employment as provided below:

1. Standards for personal protective equipment, respiratory protective equipment and other requirements for the fire service (both career and volunteer).

(b) This subchapter shall not be applicable to:

1. Construction, agriculture and maritime employment;

2. Airport crash rescue; or

3. Forest firefighting operations.

(c) The ANSI, CGA and NFPA standards incorporated in this subchapter by reference may be obtained by contacting the issuing entities at the addresses listed in N.J.A.C. 12:100-17.3.

12:100-10.2 Definitions

The following words and terms, when used in this subchapter, have the following meaning unless the context clearly indicates otherwise.

"ANSI" means American National Standards Institute.

"Approved" means the term as defined at N.J.A.C. 12:100-2.1.

"CGA" means Compressed Gas Association.

"Career firefighter" means any person who has his or her primary employment as a firefighter, who ordinarily works at that employment at least 20 hours per week and who is enrolled as a firefighter in a public retirement system.

"Career fire service" means a fire department or fire brigade which is composed of persons who have chosen firefighting or related duties as their occupation in paid, part paid fire departments or fire districts.

"Confined space" means the term as defined at N.J.A.C. 12:100-9.2.

"Damaged equipment" means equipment which has been affected by external forces such as, but not limited to, mechanical, thermal, chemical or hydraulic, to an extent whereby the equipment no longer performs its original function to the extent required for the users' safety.

"Education" means the process of imparting knowledge or skill through systematic instruction.

"Employee" means the term as defined at N.J.A.C. 12:100-2.1.

"Employer" means the term as defined at N.J.A.C. 12:100-2.1.

"Enclosed structure" means a structure with a roof or ceiling and at least two adjacent walls which may present fire hazards to employees.

"Fire brigade" means an organized group of firefighters who are public employees who have an obligation to fight fires but who may be assigned to other duties.

"Fire department" means an organized group of employees organized by the public employer who are knowledgeable, trained and skilled in basic firefighting operations.

"Firefighter" means a member of the fire service who engages in the physical activity of rescue, fire suppression or both, in buildings, enclosed structures, vehicles, vessels or like properties that are involved in a fire or emergency situation.

"Fire service" means a fire department or fire brigade.

"Helmet" means a head protective device consisting essentially of a shell, an energy absorbing system, a retention system, fluorescent retro-reflective markings, ear covers and faceshield.

"Interior structural firefighting" means the physical activity of fire suppression, rescue or both, inside of buildings or enclosed structures which are involved in a fire situation beyond the incipient stage.

"NFPA" means the National Fire Protection Association.

"Overhaul" means the final control of a fire with suppression of the main body of the fire and other pockets of fire, searching for victims and performing salvage operations.

"Positive-pressure apparatus" means an open or closed-circuit apparatus in which the pressure inside the face piece in relation to the immediate environment is positive during both inhalation and exhalation.

"Quick disconnect valve" means a hand-operated device which provides a means for connecting and disconnecting the air cylinder to the self-contained breathing apparatus.

"Respiratory protective device" means a breathing device designed to protect the wearer from an oxygen-deficient or hazardous atmosphere.

"SCBA" means self-contained breathing apparatus.

"Self-contained breathing apparatus" means a portable device that includes the supply of respirable breathing gas for the firefighter.

"Service life" means the period of time that a respirator has been rated to provide protection to the wearer.

"Unserviceable" means past useful life of garment or protective gear, or those that have been declared unsafe.

"Vapor-barrier" means that material used to substantially prevent or inhibit the transfer of water, corrosive liquid, steam or other hot vapors from the outside of a garment to the wearer's body.

"Volunteer firefighter" means any person other than a career firefighter who serves as a firefighter in a public or private firefighting agency or organization.

"Volunteer fire service" means a fire department or brigade composed of persons who provide their services without compensation in the public interest.

12:100-10.3 Organization

(a) The employer shall prepare and maintain a statement or written policy which contains the following:

1. The basic organizational structure of the fire service;

2. The expected number of members in the fire service; and

3. The functions that the fire service is to perform.

(b) The organizational statement shall be available for inspection by the Commissioner of Labor and by the employees or their designated representative.

12:100-10.4 Personnel; limitations on ability to perform

(a) The employer shall assure that employees who are expected to do interior structural firefighting are physically capable of performing duties which may be assigned to them during emergencies.

(b) The employer shall not permit employees with known heart disease, epilepsy or emphysema to participate in firefighting or emergency activities unless a physician's certificate of the fitness of the employee to participate in such activities is provided.

12:100-10.5 Protective clothing

(a) The employer shall provide, at no cost to the employee, and assure the use of, protective clothing which complies with this subchapter.

(b) Firefighters performing interior structural firefighting and overhaul shall be provided with the equipment covered in this subchapter.

(c) The employer shall assure that:

1. Protective clothing protects the head, body and extremities, and consists of at least the following components: body protection, eye, face and head protection;

2. Protective clothing ordered or purchased after the effective date of this subchapter shall comply with this subchapter; and

3. All firefighters wear protective clothing complying with this subchapter except that existing protective clothing meeting the previous OSHA standards that are superseded by this subchapter may continue to be worn until such time as the existing protective clothing becomes unserviceable.

12:100-10.6 Protective clothing; foot and leg protection

(a) Foot and leg protection shall comply with this section within two years of the effective date of this subchapter for all career firefighters, and as replacement of existing foot and leg protection is required for the volunteer firefighters.

1. Protective footwear shall comply with NFPA 1974-1987, Protective Footwear for Structural Firefighting.

i. The use of three quarter length boots may continue as follows:

(1) Until bunker pants are purchased or not later than two years of the effective date of this subchapter for career firefighter; and

(2) Until replacement of the boots is necessary for volunteer firefighters.

12:100-10.7 Protective clothing; body protection

(a) Body protection shall comply with this section within two years of the effective date of this subchapter for the career firefighters, and as replacement is required for the volunteer firefighters.

(b) Body protection shall be achieved by the wearing of a fire resistive coat and bunker pants, both of which shall be at least equivalent to NFPA 1971-1986, Protective Clothing for Structural Firefighting, incorporated herein by reference. For career firefighters, body protection must be worn in combination with a station/work uniform or apparel complying with (c) below.

(c) Station/work apparel shall be provided to the career firefighter within two years after the effective date of this subchapter as follows:

1. The performance, construction and testing of station/work uniforms shall be at least equivalent to NFPA 1975-1985, Station/Work Uniforms for Firefighters, incorporated herein by reference; or

2. Apparel issued to the firefighter must be of a non-meltable material, such as cotton.

12:100-10.8 Protective clothing; hand protection

(a) Hand protection shall consist of protective gloves or a glove system which will provide protection against cuts, punctures and heat penetration.

(b) The performance, construction and testing of gloves for structural firefighters shall be at least equivalent to NFPA No. 1973-1987, Gloves for Firefighters, incorporated herein by reference.

12:100-10.9 Protective clothing; head, eye and face protection

(a) Head protection shall consist of a protective head device with ear flaps and chin strap which meet the performance, construction and testing requirements of 29 CFR Part 1910.156(e)(5).

(b) Full facepieces, helmets, hoods or breathing apparatus which comply with 29 CFR 1910.134 and N.J.A.C. 12:100-10.10 shall be deemed to comply with (a) above.

12:100-10.10 Respiratory protection devices

(a) The employer shall provide, at no cost to the employee, and shall assure the use of, respirators which comply with this section.

(b) The employer shall assure that all firefighters wear respiratory protective devices complying with this section and that such respirators are certified in accordance with 30 CFR Part 11, Respirators.

(c) Approved self-contained breathing apparatus with a full-facepiece, or with approved helmet or hood configuration, shall be provided to, and worn by, firefighters as follows:

1. While engaged in interior structural firefighting;
2. While working in confined spaces where toxic products of combustion or an oxygen deficiency may be present;
3. During emergency situations involving toxic substances; and
4. During all phases of firefighting and overhaul.

(d) The employer shall assure that:

1. Respirators ordered or purchased after the effective date of this subchapter shall be at least equivalent to NFPA no. 1981-1987, Open-Circuit Self-Contained Breathing Apparatus for Fire Fighters; incorporated herein by reference; and
2. All firefighters shall wear respirators complying with this subchapter except that existing respirators meeting the previous OSHA standards that are superseded by this subchapter may continue to be worn until such time as the respirator becomes unserviceable.

(e) The employer shall establish and maintain a respiratory protection program which includes the requirements of ANSI Z88.5-1981, Practice for Respiratory Protection for the Fire Service, incorporated herein by reference, except that:

1. Self-contained breathing apparatus regulators shall be subject to overhaul and recalibration at least every two years or when damaged. Such overhaul shall be performed by the manufacturer or by personnel trained and certified by the self-contained breathing apparatus manufacturer to perform such repairs;
2. Negative-pressure self-contained breathing apparatus with a rated service life of more than two hours and which has a minimum protection factor of 5,000, as determined by an acceptable quantitative fit test performed on each individual, shall be acceptable for use only during those situations for which the employer demonstrates that long duration breathing apparatus is necessary.

i. Quantitative fit test procedures shall be available for inspection by the Commissioner of Health.

ii. Negative-pressure breathing apparatus shall continue to be acceptable for 18 months after a positive-pressure breathing apparatus with the same or longer rated service life is certified by the National Institute of Occupational Safety and Health (NIOSHA). After this 18-month period, all self-contained breathing apparatus used for these long duration situations shall be of the positive-pressure type.

(f) Existing respirators meeting the previous OSHA standards that are superseded by this Subchapter:

1. May be used with approved cylinders from other approved self-contained breathing apparatus provided that such cylinders are of the same capacity and pressure rating. All compressed air cylinders used with self-contained breathing apparatus shall meet the criteria of 49 CFR Parts 100 through 199 and 30 CFR Parts 11, 12, 13, 14 and 14a;
2. Can be switched from a demand to a positive pressure mode. However, such apparatus shall be in the positive pressure mode when firefighters are performing interior structural firefighting operations or overhaul.

(g) The employer shall have a written plan to assure that there are sufficient quantities of compressed air available to refill self-contained breathing apparatus tanks for all emergencies.

(h) Self-contained breathing apparatus shall be provided with an end of service time indicator which automatically warns the user when the remaining service time for the apparatus is reduced to a range of 20 to 25 percent of its rated service time.

12:100-10.11 Life-safety rope, harnesses and hardware

(a) This section is intended to apply to fire departments that train and perform rope rescue services. All employees that are required by the fire department to participate in such rescue services shall be provided with the proper equipment meeting the requirements of this section.

(b) The employer shall provide, at no cost to the employee, and assure the use of, life-safety rope, harnesses, and hardware which comply with this section.

(c) The employer shall assure that the life-safety rope, harnesses and hardware complying with this section are used to support fire service personnel during rescue, firefighting, and other emergency operations, or during training exercises, on a date not later than one year after the effective date of this subchapter.

(d) The performance, construction and testing of ropes, harnesses, and hardware for firefighters shall be at least equivalent to NFPA No. 1983-1985, Fire Service Life-Safety Rope, Harnesses and Hardware, incorporated herein by reference.

(e) Life-safety rope, harnesses and hardware need only be provided in those departments that perform rope rescue services and to employees who perform such services.

12:100-10.12 Personal alert safety system

(a) The employer shall provide, at no cost to the employee, and assure the use of, a personal alert safety system attached to every self-contained breathing apparatus (SCBA) which complies with this section.

(b) The employer shall assure that all firefighters wear personal alert safety systems that comply with this section within one year after the effective date of this subchapter, except that personal alert safety systems complying with NFPA standard 1982-1983 may continue to be used until they become unserviceable.

(c) The performance, construction and testing of a personal alert safety system for a firefighter shall be at least equivalent to NFPA No. 1982-1988, Personal Alert Safety Systems (PASS) for Firefighters, incorporated herein by reference.

(d) Approved personal alert safety systems shall be provided and worn by the firefighter as follows:

1. While engaged in interior structural firefighting;
2. While working in confined spaces;
3. During all phases of overhaul; and
4. As an attachment to the SCBA device worn by the firefighter.

12:100-10.13 Hearing protection

(a) This section is intended to provide hearing protection to the firefighter in non-emergency situations. An example of a non-emergency situation requiring hearing protection to the employee would be during the testing of equipment creating a noise level exceeding 90 decibels (dBa). The hearing conservation program described should be in writing and may be incorporated into standard operating procedures (SOP).

(b) The fire department shall provide hearing protection for all members when they are exposed to noise in excess of 90 dBa from power tools or equipment, except for situations where the use of hearing protection devices would create an additional hazard to the user.

(c) The fire department shall engage in a hearing conservation program to identify and reduce or eliminate potentially harmful sources of noise in the work environment.

(d) The provisions of CFR 1910.95, Occupational Noise Exposure, incorporated at N.J.A.C. 12:100-4.2(a)5, Subpart g, Occupational Health and Environmental Control, is applicable to this subchapter.

12:100-10.14 Filling air cylinders

(a) Air cylinders shall be refilled in accordance with CGA P-15-1985, Filling of Industrial and Medical Nonflammable Compressed Gas Cylinders, incorporated herein by reference.

(b) Air cylinders for respiratory equipment shall be filled only by personnel trained pursuant to (a) above and (c) below.

(c) The charging station shall be equipped with proper facilities to ensure the safety of the charging station operator and nearby personnel.

(d) The charging station shall be equipped with proper facilities to ensure that the compressed air complies with Type 1 Grade D breathing air as described in CGA G7.1-1973, Commodity Specification for Air, incorporated herein by reference.

12:100-10.15 Fire apparatus operations

(a) Whenever a fire apparatus leaves the fire station in response to an alarm, fire or other emergency, all firefighters, except the driver of the fire apparatus, shall have donned their protective clothing before the apparatus is in motion. All firefighters shall be prohibited from donning protective clothing while the apparatus is in motion. The term "fire apparatus" does not include an automobile.

(b) The employer shall provide restraining devices for all firefighters aboard a fire apparatus within five years after the effective date of this subchapter. Restraining devices may include protective seating, seatbelts or vehicle harnesses for all firefighters aboard.

(c) All fire apparatus purchased and/or remanufactured after the effective date of this subchapter shall provide enclosed seating with seatbelts for all personnel riding on the apparatus, complying with the following standards, incorporated herein by reference:

1. NFPA No. 1901-1991 Pumper Fire Apparatus;

2. NFPA No. 1902-1991 Initial Attack Fire Apparatus;

3. NFPA No. 1903-1991 Mobile Water Supply Fire Apparatus; and

4. NFPA No. 1904-1991 Aerial Ladder and Elevating Platform Apparatus.

12:100-10.16 Maintenance of firefighter equipment

Firefighting equipment required under this subchapter that is in damaged or unserviceable condition shall be removed from service and replaced.

12:100-17.1 Documents referred to by reference

(a) The full title and edition of each of the standards or publications referred to in this chapter are as follows:

1. (No change.)

2. [ANSI Z88.6-1984, Respiratory Protection-Respiratory Use-Physical Qualifications for Personnel] **ANSI Z88.5-1981, Respiratory Protection for the Fire Service;**

3. ANSI Z88.6-1984, Respiratory Protection-Respiratory Use-Physical Qualifications for Personnel;

Recodify existing 3.-8. as **4.-9.** (No change in text.)

10. CGA G7.1-1973, Commodity Specification for Air;

11. CGA P15-1985, Filling of Industrial and Medical Nonflammable Compressed Gas Cylinders;

12. NFPA No. 1971-1986, Protective Clothing for Structural Firefighting;

13. NFPA No. 1972-1987, Structural Firefighters Helmets;

14. NFPA No. 1973-1989, Gloves for Structural Firefighters;

15. NFPA No. 1974-1987, Standard on Protective Footwear for Structural Firefighting;

16. NFPA No. 1975-1985, Station/Work Uniforms for Firefighting;

17. NFPA No. 1981-1986, Self-contained Breathing Apparatus for Firefighters;

18. NFPA No. 1982-1988, Personal Alert Safety System for Firefighters (PASS);

19. NFPA No. 1983-1985, Fire Service Life-Safety Rope, Harnesses, and Hardware;

20. NFPA No. 1901-1991, Pumper Fire Apparatus;

21. NFPA No. 1902-1991, Initial Fire Apparatus;

22. NFPA No. 1903-1991, Mobile Water Supply Fire Apparatus;

23. NFPA No. 1904-1991, Aerial Ladder and Elevating Platform Apparatus;

Recodify existing 9.-13. as **24.-28.** (No change in text.)

12:100-17.3 Availability of documents from issuing organization

Copies of the standards and publications referred to in this chapter may be obtained from the organizations listed below. The abbreviations preceding these standards and publications have the following meaning, and are the organizations issuing the standards and publications listed in N.J.A.C. 12:100-17.1.

ANSI (No change.)

...

CGA	**Compressed Gas Association Inc.** **1235 Jefferson Davis Highway, Suite 509** **Arlington, VA 22202**
NFPA	**National Fire Protection Association** **Batterymarch Park** **Quincy, MA 02269**

...

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

Restricted Stopping and Parking Route U.S. 9 in Cape May County

Proposed Amendment: N.J.A.C. 16:28A-1.7

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6, and 39:4-138.1.

Proposal Number: PRN 1992-14.

Submit oral or written comments by February 5, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625
(609) 530-2041

The agency proposal follows:

Summary

The proposed amendment will establish a "restricted parking and stopping" zone along both sides of Route U.S. 9 in Middle Township, Cape May County, for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace.

Based upon request from the local government in the interest of safety, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation and resurvey proved that the establishment of the "restricted parking and stopping" zone along Route U.S. 9 in Middle Township, Cape May County, was warranted.

The Department therefore proposes to amend N.J.A.C. 16:28A-1.7 based upon the request from the local government and the traffic investigation.

Social Impact

The proposed amendment will establish a "restricted parking and stopping" zone along both sides of Route U.S. 9 in Middle Township, Cape May County, for the efficient flow of traffic, the enhancement of safety, and the well-being of the populace. 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 "restricted parking and stopping" zone 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 amendment 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 amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

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

16:28A-1.7 Route U.S. 9

(a) The certain parts of State highway Route U.S. 9 described in this subsection shall be designated and established as "no stopping or standing" zones.

1.-11. (No change.)

12. No stopping or standing in Middle Township, Cape May County[:

i. Along both sides:

(1) From the northerly curb line of Pacific Avenue to a point 100 feet north therefrom;

(2) From the southerly curb line of Romney Place to the southerly curb line of Orbit Drive;

(3) From a point 150 feet south of the southerly curb line of Brooks Avenue to a point 450 feet north of the northerly curb line of Brooks Avenue.

(4) From the northerly curb line of the Garden State Parkway Exit 8 to the northerly curb line of 3rd Avenue.

ii. Along the easterly (northbound) side;

(1) From the southerly curb line of Colonial Avenue to a point 100 feet southerly therefrom;

(2) From the northerly curb line of Colonial Avenue to a point 100 feet northerly therefrom.

(3) From the northerly curb line of Atlantic Avenue to the prolongation of the southerly curb line of School House Lane.] **for the entire length within the corporate limits, including all ramps and connections thereto, which are under the jurisdiction of the Commissioner of Transportation; except in bus stops and time limited parking areas designated by this section.**

13.-20. (No change.)

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

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

Turn Prohibitions
Route U.S. 206 in Mercer County
Proposed Amendment: N.J.A.C. 16:31-1.1

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 and 39:4-183.6.

Proposal Number: PRN 1992-16.

Submit comments by February 5, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment will establish a "no left turn" prohibition along Route U.S. 206 in Lawrence Township, Mercer County, for the safe and efficient flow of traffic, the enhancement of safety, and the well-being of the populace.

Based upon request from the local government in the interest of safety, and as part of a review of current conditions, the Department's Bureau of Traffic Engineering and Safety Programs conducted a traffic investigation. The investigation proved that the establishment of "no left turn" along Route U.S. 206 in Lawrence Township, Mercer County, was warranted.

The Department therefore proposes to amend N.J.A.C. 16:31-1.1 based upon the request from the local government and the traffic investigation.

Social Impact

The proposed amendment will establish a "no left turn" prohibition along Route U.S. 206 in Lawrence Township, Mercer County, for the safe and efficient flow of traffic, the enhancement of safety, and the well-being of the populace. 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 "no left turn" zone 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 amendment 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 amendment primarily affects the motoring public and the governmental entities responsible for the enforcement of the rules.

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

16:31-1.1 Route U.S. 206

(a) Turning movement of traffic on the certain parts of State highway Route U.S. 206 described in this [section] **subsection** are regulated as follows:

1.-4. (No change.)

5. No left turn in Lawrence Township, Mercer County:

1. From Route U.S. 206 northbound onto Monroe Avenue and Hendrickson Road between the hours of 7:00 A.M. and 9:00 A.M. and 4:00 P.M. and 6:00 P.M. Monday through Friday.

(b)

DIVISION OF TRANSPORTATION ASSISTANCE
Office of Regulatory Affairs
Practices and Procedures before the Office of Regulatory Affairs
Proposed Readoption with Amendments: N.J.A.C. 16:51

Authorized By: George Warrington, Deputy Commissioner, Department of Transportation.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, and 52:14B-3.

Proposal Number: PRN 1992-6.

Submit oral or written comments by February 5, 1992 to:

Charles L. Meyers
Administrative Practice Officer
Department of Transportation
Bureau of Policy and Legislative Analysis
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625
(609) 530-2041

The agency proposal follows:

Summary

Under the provisions of Executive Order No. 66(1978), N.J.A.C. 16:51, Practices and Procedures Before the Office of Regulatory Affairs, is scheduled to expire on April 6, 1992. The original rules were proposed in the New Jersey Register at 19 N.J.R. 182(a), and adopted at 19 N.J.R. 553(c). The rules were amended at 20 N.J.R. 2635(b), and 21 N.J.R. 776(a). The rules were reviewed by the staff of the Office of Regulatory Affairs and were found to be necessary, adequate, reasonable, efficient, understandable and responsive to the purpose for which they were promulgated. Staff recommended that minor changes be effected to update the rules to comply with current practices and procedures. N.J.A.C. 16:51-1.3 is being amended to effect the change in title of the Assistant Commissioner from that "of Transportation Services" to "of Policy and Planning" to comply with the recent reorganization of the Department.

N.J.A.C. 16:51-1.4 is being amended to effect the change in location of the Office of Regulatory Affairs from 744 Broad Street, Suite 502,

Newark, New Jersey 07102 to 1600 North Olden Avenue, Ewing Township, New Jersey 08638.

N.J.A.C. 16:51-1.6 is being amended to show the new addresses required for forwarding correspondence and pleadings if sent by mail and if by premium or courier service.

The Department therefore proposes to readopt N.J.A.C. 16:51.

The Chapter is summarized as follows:

Subchapter 1 notes general provisions, including office hours and the location of the Office Of Regulatory Affairs and defines terms pertinent to proceedings before the Office.

Subchapter 2 outlines the procedure to be followed in pleadings.

Subchapter 3 outlines the requirements concerning petitions for certificates of public convenience and necessity to conduct autobus operations.

Subchapter 4 contains the rules on proper content and filing of motions regarding proceedings at the Office of Regulatory Affairs.

Subchapter 5 contains the rules for having matters reheard, reargued or reconsidered.

Subchapter 6 explains the use of informational conferences in autobus regulatory proceedings.

Subchapter 7 through 13 pertain to respective duties of licensed autobus companies: accident reporting; provision of service; autobus company office requirements; autobus company records; tariff filings; notices regarding fare or schedule changes; and compliance with Department decisions and recommendations.

Social Impact

The proposed readoption with amendments clarifies the role of the Department in the regulation of autobus and street railway matters. The rules call for added disclosure by applicants in their written requests for autobus licensure or amendment thereto.

The rules also ensure receipt of adequate notice of licensure proceedings by potentially interested or affected parties, such as municipal and county officials, the general public and other passenger carriers, and expeditious determinations of issues properly presented to the Office of Regulatory Affairs. This chapter also provides, in Subchapter 8, standards to be followed which govern the provision of service to the general public.

Since these rules were effected, the Department, over the past five years, has had no social problems with practice or procedures outlined therein. The proposed amendments will have no effect on the rules' necessity or operation. If this chapter is not readopted, the Department will be left without the necessary mechanism to govern the operational and administrative duties of licensed autobus companies and street railways, as required by statutes.

Economic Impact

The proposed readoption with amendments is expected to add predictability to the autobus regulatory application and, hence, result in time and cost savings for petitioners and other parties to proceedings before the Office of Regulatory Affairs.

There has been no economic impact in the past and although economic conditions of the past have changed, this economic change has not necessitated any changes in the rules, and the proposed amendments to this rule have effected no procedural changes which affect the industry. If the rules were not readopted, the Department would not be complying with the requirements established by statutes.

Regulatory Flexibility Statement

The proposed readoption with amendments does place reporting, recordkeeping and compliance requirements on small business as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. These requirements involve the operation of the agency, including provision of service to the general public; the conduct of hearings; the means by which the regulated utilities must maintain records; and the requirements placed upon the utilities for service to the public. Some of the requirements, such as the submission of petitions and motions and participation in hearings may require professional services, such as those of an attorney. Since the information required is necessary for determinations by the Office of Regulatory Affairs, an elimination or reduction in these requirements for small business would be detrimental to the regulatory process, and hence, is not provided. The rules are liberally construed to permit the Office to effectively carry out its statutory functions and to secure just and expeditious determinations of issues properly presented to it, regardless of the size of the business.

Full text of the proposed readoption may be found in the New Jersey administrative code at N.J.A.C. 16:51.

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

16:51-1.3 Definitions

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

...

"Commissioner" means the Commissioner of the Department of Transportation or, in his or her absence, the Assistant Commissioner [of Transportation Services] **for Policy and Planning.**

...

16:51-1.4 Offices

The Office of Regulatory Affairs is **physically** located at [744 Broad Street, Suite 1502, Newark, New Jersey 07102] **1600 North Olden Avenue, Ewing Township, New Jersey 08638** or such other location as publicly noted.

16:51-1.6 Communications

(a) All pleadings, correspondence and other papers shall be addressed, **if sent by U.S. mail,** to the Director, Office of Regulatory Affairs, New Jersey Department of Transportation, [744 Broad Street, Suite 1502, Newark, New Jersey 07102] **1035 Parkway Avenue, CN 611, Trenton, New Jersey 08625** and shall include the appropriate Department docket number.

(b) Pleadings, correspondence and other papers, if sent by private premium service, or by courier service, shall be addressed as in (a) above, but may be sent to the Director, Office of Regulatory Affairs, New Jersey Department of Transportation, 1600 North Olden Avenue, Ewing Township, New Jersey 08638.

Recodify (b)-(c) as **(c)-(d)** (No change in text.)

16:51-11.2 Letter of transmittal

(a) (No change.)

(b) The letter of transmittal shall take the following form:

LETTER OF TRANSMITTAL
(Name of Common Carrier)

Transmittal Advice No. _____ Place and Date _____

To: Office of Regulatory Affairs
State of New Jersey
[Newark] **Trenton**, New Jersey

The enclosed tariff, issued _____ is transmitted for filing in compliance with the requirements of the Department of Transportation, State of New Jersey.

(If a complete tariff)

N.J.D.O.T. (P.U.C.N.J. or I.C.C.) No. _____ Effective _____

(Or if a revised page)

_____ Revised Page No. _____

Effective _____

(Or if a supplement)

Supplement No. ___ to N.J.D.O.T. (P.U.C.N.J. or I.C.C.) No. ___

Effective _____

_____
(Name of Utility)

_____
(Signature of Officer Transmitting)

16:51-11.11 Less than 30 days' notice request; application

(a) Any common carrier desiring permission to change existing rates on less than 30 days' notice shall file with the Department a tariff, part of tariff, or supplement, if necessary, containing the

proposed change and the application in the form prescribed herein requesting authority to put such tariff into effect in less than 30 days after filing, and indicating the date it is desired that such rates become effective. Where special conditions arise necessitating a change in the proposed effective date, extension may be requested. Such application shall be contained in the statement of tariff changes.

APPLICATION FOR AUTHORITY TO MAKE CHANGES EFFECTIVE ON LESS THAN THIRTY DAYS NOTICE

To: Office of Regulatory Affairs
State of New Jersey
[Newark] **Trenton**, New Jersey

_____
(Name of Common Carrier) by (Name of Officer)

its (Title of Officer) _____ hereby applies for _____ authority to make effective the following rates, N.J.D.O.T. or (P.U.C.N.J. or I.C.C.) No. _____ on _____ 19____ by filing with the Department on days notice. This application is based upon the following special circumstances and conditions:

_____ (Name of Utility)

_____ (Name and title of authorized representative

(b) (No change.)

_____

(a)

DIVISION OF TRANSPORTATION ASSISTANCE
OFFICE OF AVIATION
Notice of Pre-Proposal
Licensing of Aeronautical and Aerospace Facilities
Pre-Proposed Repeals and New Rules: N.J.A.C. 16:54

Authorized By: George Warrington, Deputy Commissioner, Department of Transportation.
Authority: N.J.S.A. 27:1A-5, 27:1A-6, 6:1-29, and 6:1-43.
Pre-Proposal Number: PPR 1992-1.

Submit comments in writing, by March 7, 1992 to:
Charles L. Meyers
Administrative Practice Officer
Department of Transportation
1035 Parkway Avenue
CN 600
Trenton, New Jersey 08625

This is a notice of Pre-Proposal for a rule (see N.J.A.C. 1:30-3.2). Any rule concerning the subject of this pre-proposal must still comply with the rulemaking provisions of the Administrative Procedure Act, N.J.S.A. 52:14B et seq., as implemented by the Office of Administrative Law's Rules for Agency Rulemaking, N.J.A.C. 1:30.

The agency pre-proposal follows:

Summary

Aviation facilities and activities in the State are subject to regulation under the provisions of N.J.S.A. 27:1A-5. The rules promulgated pursuant to that statute, N.J.A.C. 16:54, have been in effect for nearly a decade and are in need of revision to reflect current technology and standards.

The Department is proposing new rules to replace the current N.J.A.C. 16:54, Licensing of Aeronautical Facilities. The pre-proprosed new rules will clarify and reconfirm the Department's jurisdiction over airports and their associated activities. While some sections of text may remain from the old rules, new material is extensive and comprehensive. Some sections of text are still under development and are so identified. Comments of the public and regulated persons are a valuable resource and are of interest to the Department in the promulgation of these rules.

The Department has initiated this pre-proposal to get public input and to assist in the fact finding efforts of the Office of Aviation. This pre-proposal seeks public comment on the proposed text. All interested persons are requested to forward their written comments to the Department. Where possible, comments should refer, by N.J.A.C. citation, to the specific area of the rules being commented upon.

N.J.A.C. 16:54-4, 5, 6.3, 6.4 and 6.5 all address general requirements, design standards, and operational standards for each of the specific facilities licensed. These requirements and standards are still being developed by incorporating or modifying valid portions of the current N.J.A.C. 16:54, adopting new standards where none existed, and incorporating by reference certain Federal regulations and guidelines relative to the development and use of aeronautical facilities. In part, these are: Federal Aviation Regulations (FAR) Part 77, Objects Affecting Navigable Airspace; FAR Part 157, Notice of Construction, Alteration, Activation, and Deactivation of Airports; Federal Aviation Administration (FAA) Advisory Circulars 150/5300-13, Airport Design, 150/5390-2, Heliport Design, and 150/5390-3, Vertiport Design. Others may be adopted by reference as needed.

N.J.A.C. 16:54-3.3 is reserved for future use, should aerospace facilities be developed in the State.

N.J.A.C. 1:30-3.3 requires a public comment period for pre-proposal of at least 30 days. To promote public input, the Department has decided to have a 60 day comment period for this pre-proposal. In addition to written comments, interested parties may request the opportunity to supplement written with oral presentations (see N.J.A.C. 1:30-3.2(b)4). The Department may also decide to hold a public hearing in conjunction with this pre-proposal. If a public hearing is held, notice of that hearing will be made in conformance with the provisions of N.J.A.C. 1:30-3.3(b).

N.J.A.C. 16:54-2 includes a reference to a fee schedule, which is in the process of development and will be located at N.J.A.C. 16:54A.

Full text of the current rules appears in the New Jersey Administrative Code at N.J.A.C. 16:54.

Full text of the pre-proposed new rules follows:

CHAPTER 54
LICENSING OF AERONAUTICAL AND AEROSPACE FACILITIES

SUBCHAPTER 1. GENERAL PROVISIONS

16:54-1.1 Scope

(a) This chapter lists and defines those types of aeronautical and aerospace facilities which must be licensed by the State of New Jersey and includes the ancillary operations thereon as hereinafter defined; outlines the procedures for obtaining license(s); specifies the licensing requirements which applicants must meet; specifies the minimum acceptable design standards for each type of facility; specifies certain operational standards for each type of facility; specifies the liability and penalty for failure to observe the requirements; and describes the procedure for requesting exemption from these rules.

(b) The rules specified in this chapter, if not in conformity with the laws, rules, and regulations concerning aeronautics set forth by the Federal Aviation Administration or the National Aeronautics and Space Administration, are subject to preemption. If not specifically preempted by Federal standards, complete discretion over the regulating and licensing of aeronautical activities and facilities in New Jersey resides with the Commissioner, as provided for in N.J.S.A. 6:1-29 et seq.

16:54-1.2 Applicability

(a) The provisions of this chapter apply to the following types of aeronautical facilities:

1. Fixed wing aeronautical facility:
i. Airport—Public Use (land or water);
ii. Landing Strip—Public Use (land or water);
iii. Airport—Restricted Use (land or water);
iv. Landing Strip—Restricted Use (land or water);
v. Airport—Special Use (land or water); and
vi. Landing Strip—Special Use (land or water).
2. Vertical flight aeronautical facility:
i. Heliport—Public Use;
ii. Heliport—Restricted Use;
iii. Helistop—Restricted Use;
iv. Helistop—Special Use;
v. Vertiport—Public Use;

vi. Vertiport—Restricted Use; and
vii. Vertiport—Special Use.
3. Lighter than air aeronautical facility:
i. Balloonport—Public Use;
ii. Balloonport—Restricted Use;
iii. Balloonport—Special Use;
iv. Airship Base—Public Use;
v. Airship Base—Restricted Use; and
vi. Airship Base—Special Use.
4. Parachute drop zone aeronautical facility:
i. Parachute Drop Zone—Public Use;
ii. Parachute Drop Zone—Restricted Use; and
iii. Parachute Drop Zone—Special Use.
5. Aerospace facilities:
i. Spaceport—Public Use;
ii. Spaceport—Restricted Use; and
iii. Spaceport—Special Use.
6. Temporary aeronautical facilities:
i. Airship base;
ii. Balloonport;
iii. Helistop;
iv. Landing strip;
v. Parachute drop zone;
vi. Vertiport; and
vii. Other.

16:54-1.3 Abbreviations and definitions

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

(a) Abbreviations:

DOT—New Jersey Department of Transportation
FAA—Federal Aviation Administration
M—Meters
MSL—Mean Sea Level
NASA—National Aeronautics & Space Administration
NJ—New Jersey
VFR—Visual Flying Rules

(b) Definitions:

"Aeronautical activity" means any aviation related services provided at an airport by the licensee or his tenants or invitees with or without compensation, to the public or any segment thereof. Activities may include, but are not limited to: aerial advertising; aerial applications; aerial photography operations; aircraft catering; aircraft corrosion control; aircraft painting; aircraft fueling; aircraft maintenance, modification, alteration or repair; aircraft rental; banner towing; classroom instruction for airman certification; fish spotting operations; flying clubs; flight simulator training; flight training or instruction; parachute repair; parachute rigging; pipe or powerline patrols; sale, servicing, or repair of aviation electronics or other avionics equipment; sale of aircraft, aircraft parts, equipment or materials; retail sales of aircrew and aircraft equipment, clothing, memorabilia, gifts; or any other operation deemed appropriate by the Commissioner. Food and beverage facilities not related to aircraft catering operations are not included but may be co-located on an aeronautical facility.

i. For the purposes of land use and zoning, at public use aeronautical facilities, any aeronautical activity is considered a permitted use; at restricted use and special use aeronautical facilities, any aeronautical activity is considered a conditional use and requires specific approval by the Office of Aviation.

"Aeronautical facility" means any landing strip, airport, seaplane base, heliport, helistop, drop zone, blimp mooring mast, or balloonport.

i. The facility includes all property, paving, appliances, structures, seaplane docks, runways, taxiways, seaways, sealanes, aprons, hangers, or safety equipment associated with the aeronautical activities conducted on the premises and property.

"Aerospace facility" is any facility used for the launch or recovery of space vehicles.

"Aircraft" means any contrivance now known or hereafter invented, used or designed for avigation or flight in the air. It includes, but is not limited to: airplanes, blimps, dirigibles, gyroplanes, gliders, helicopters, hot air or gas balloons, seaplanes, tiltrotors, and ultra lights.

"Airplane" means an engine-driven, fixed-wing aircraft that is heavier than air that is supported in flight by the dynamic reaction of air against its wings.

"Airport" means a designated area of land, water, or both, which is licensed for the landing and take-off of airplanes and other aircraft, and which provides facilities for shelter, security, and service of aircraft.

"Airship" means an aircraft, lighter than air, engine driven that can be steered.

"Airship base" means any area of land or water of defined dimensions licensed for the takeoff and landing of airships.

"Alteration" means any construction, demolition, or modification to the surface, design, or operational areas of an aeronautical facility which affects, increases, or diminishes its operational capabilities.

"Approach/departure path" (pertains to operation of rotary wing aircraft) means a prescribed flight track extending outward and upward from the edge of a landing and takeoff area, along which normal flight is conducted to and from an approved aeronautical facility.

"Avigation" means the operating, steering, directing, or managing of aircraft in or through the air, and on the ground or water.

"Balloon" means a lighter than air aircraft whose lift is derived from the buoyancy of hot air or certain gases and which is not engine driven.

"Balloonport" means any areas of land or water of defined dimensions licensed for the takeoff of manned, free-flight balloons used for commercial purposes.

"Building restriction line" means a line that is a specified distance from the centerline of a runway. Between this line and the runway, there may be no buildings, structures, trees or other such permanent or semipermanent obstructions.

"Commercial operation" means any exhibition, demonstration, meet, student or upgrade training, research, development, flight-testing, carrying of passengers or goods, with or without compensation, where members of the general public are notified of, or invited by any means whatsoever, to observe or participate in such activities.

"Commissioner" means the Commissioner of the New Jersey Department of Transportation.

"Crew member" means an individual used to assist in the preflight inflation, launch, chase, landing (arrival) and recovery of a balloon, or any person authorized and assigned to perform duties in an aircraft during flight.

"Director" means the Director of the New Jersey Office of Aviation.

"Free-flight" (pertains to the operation of balloons) means the act of flying a manned balloon which is not tethered to the ground.

"Helicopter" means a rotary wing aircraft that depends principally upon the lift generated by engine-driven rotors rotating on a substantially vertical axis for its primary means of propulsion.

"Heliport" means a dedicated area of defined dimensions, either at ground level or elevated on a structure, designated for the landing or take off of helicopters and used solely for that purpose.

"Helistop" means an area of defined dimensions, either at ground level or elevated on a structure designated for the landing or takeoff of helicopters, but not limited in use to that sole purpose. Helistops generally provide minimal or no support facilities and may be located in multiple use areas such as parking lots, dock areas, parks, athletic fields or other suitable open areas.

"Landing strip" means any area of land, water, or both, which is licensed for the landing or takeoff of airplanes and other aircraft. It differs from an airport in that it has no facilities for shelter, security, and service of aircraft.

"Landing and takeoff area" (pertains to the operation of helicopters) means a specific area of defined dimensions to which the helicopter approaches for landing or from which it departs, and includes the touchdown area.

"Licensee" means any person(s) whose name appears on the license of, and who is responsible for, or who controls operations at, an aeronautical facility.

"Moored or tethered flight" means the act of operating a balloon secured to the ground by sufficient and suitable means to permit vertical movements where no intention of launch into free-flight exists.

"Obstruction to air navigation" means an object of greater height than any of the heights or surfaces presented in Subpart C of FAR Part 77. (Obstructions to air navigation are presumed to be hazards to air navigation until an FAA study has determined otherwise.)

"Office" means the Office of Aviation in the New Jersey Department of Transportation.

"Parachute drop zone" means an area of defined dimensions, on the earth's surface, designated for the landing of parachutists.

"Parachuting exhibition" means the operation of specially qualified individual(s) engaged in parachuting to a specifically authorized drop zone, for exhibition purposes.

"Public use facility" means any area of land, water, or both which is licensed for the landing or takeoff of airplanes and other aircraft and open to the public for aeronautical operations. They may be utilized, advertised, and represented as such.

"Reference point" (helicopters only) means a point on the earth's surface, identified in terms of latitude and longitude to the nearest second, from which all linear measurements originate when applying the criteria of this subchapter to helicopter facilities. The facility reference point will always be the exact center of the helicopter touchdown area.

"Restricted use facility" means any area of land, water or both, which is licensed for the landing or take-off of aircraft under the conditions or restrictions imposed by the Office of Aviation, the licensee, or both.

"Runway" means a defined rectangular area of airport land prepared for the landing or take off of aircraft along its length.

"Runway safety area" means an area in which a runway is symmetrically located and is graded to be smooth and level. These areas are to be maintained in such a condition that aircraft operating thereon may do so, safely with no damage.

"Safety area" means a safety zone that provides an additional obstruction-free surface on all sides of a prescribed helicopter landing and takeoff area.

"Sealane" means a designated portion of water intended to be used by aircraft designed to operate on water.

"Seaplane base" means any landing area of water (with or without land support facilities) that is licensed for the landing or takeoff of aircraft that are able to utilize a water surface.

"Shelter" means an enclosed structure to provide for the comfort of persons against rain, wind, sun and adverse weather.

"Sketch" means a drawing, to scale, that is clear, concise and which includes all required details. A sketch may be hand drawn and need not be certified by an engineer or land surveyor.

"Space port" is any aerospace facility.

"Special use facility" means any area of land, water or both, which is licensed for the landing and takeoff of designated aircraft by specified individuals, as authorized by the Office of Aviation. Aeronautical activities are not permitted at these facilities except when specifically authorized by the license.

"Taxiing" means a powered movement of an aircraft on the ground or water from one area to another. Helicopters may hover-taxi as well as ground taxi dependent upon type of landing gear and the surface area being used.

"Taxiway" means a defined pathway established for movement of an aircraft on an aircraft facility.

"Touchdown area" means a defined part of the heliport/helistop to which a helicopter shall approach and actually alight (or come to a zero forward ground speed hover from the approach prior to touchdown or taxiing to another area) and from which helicopter departures shall originate.

"Touchdown pad" means a designated area of the facility on which a helicopter will actually alight.

"Vertical flight aircraft" means any aircraft which is capable of vertical or near vertical take off and landing operations including, but not limited to, rotor wing aircraft, tiltrotor aircraft, tilt wing aircraft, and fan in wing aircraft.

"Vertiport" means any area of land or water or elevated area of defined dimensions licensed for the take off and landing of vertical flight aircraft.

(c) Other definitions as described in Title 14 Code of Federal Regulations, Chapter 1 through 199, the FAA Airmans Information Manual and FAA Advisory Circulars are incorporated herein by reference, and all amendments thereto, except where the definitions are inconsistent with this chapter, in which case, this chapter shall control.

SUBCHAPTER 2. APPLICATION FOR LICENSE

16:54-2.1 Application forms for permanent facilities

(a) All persons proposing the opening of a new aeronautical facility, the alteration to, or deactivation or abandonment of, an existing aeronautical facility listed in N.J.A.C. 16:54-1.2 shall:

1. Submit an "Application for Aeronautical Facility License" Form DA-1, and "Aeronautical Facility Agreement" Form DA-2, or "Application for Aeronautical Facility Alteration, Deactivation, or Abandonment", Form DA-3, including all applicable attachments and FAA Form 7480-1 "Notice of Landing Area Proposal" if required. Such application shall include, at a minimum:

i. Form DA-1 applications, all of the applicable items listed in this section;

ii. For Form DA-3 applications, resubmission of required attachments which are presently on file in the Office of Aviation, with current date, may be waived by the Director;

iii. A description of the expected use and activity level of the new altered facility;

iv. A certificate or statement from the applicant that he has advised the appropriate governing body of his proposed action, as submitted in the application;

v. Additional materials as may be requested by the Director; and to substantiate the application; and

vi. The appropriate application fee;

2. Submit a scaled plan drawing or an annotated scaled aerial photograph, and a scaled profile drawing, as follows, certified as accurate by a licensed land surveyor, or a licensed professional engineer. For alterations to restricted or special use facilities, the engineering certification requirement may be waived by the Director. A licensed professional engineer or registered architect must certify that the load bearing capability structural limits of any structure proposed for an elevated heliport or helistop is sufficient for the type of operations anticipated. An official copy of the certification must be included with the application. For abandonment or deactivation of any facility, certified drawings are not required.

i. For airports or landing strips, using a scale of one inch equals 400 feet showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field elevation (MSL);

(4) Actual length and width, of runway(s);

(5) Magnetic alignment of runway(s) to nearest second;

(6) Location(s) use, and height(s), of structures on or proposed for the facility;

(7) Location(s), use, and height(s) (MSL), of obstruction(s) in the Hazard Zone Area if applicable;

(8) Location(s), use, and height(s) (MSL), of obstruction(s), where Hazard Zoning does not apply, contiguous to the facility within at least 3000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);

(9) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated; and

(10) Facility property lines and municipal boundaries.

ii. For heliports or helistops, using a scale of one inch equals 50 feet showing:

(1) True north;

(2) Latitude and longitude to the nearest second;

(3) Field elevations (MSL);
(4) Actual dimensions of the touchdown area;
(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1000 feet of the reference point;
(6) Location(s) of approach/departure path(s); and
(7) Facility property lines and municipal boundaries.

iii. For heliports and helistops using a scale of one inch equals 400 feet showing:
(1) Location(s) and height(s) (MSL) of any obstructions within a radius of 3000 feet of the reference point;
(2) Location(s) of approach/departure path(s); and
(3) Facility property lines and municipal boundaries.

iv. For vertiports, using a scale of one inch equals 100 feet showing:
(1) True north;
(2) Latitude and longitude to the nearest second;
(3) Field elevation (MSL);
(4) Actual dimensions of the touchdown area;
(5) Magnetic alignment of runway(s) to nearest second; and
(6) Location(s), use, and height(s), of structures on or proposed for the facility.

v. For vertiports, using a scale of one inch equals 400 feet showing:
(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Hazard Zone Area if applicable;
(2) Location(s), use, and height(s) (MSL), of obstruction(s), where Hazard Zoning does not apply, contiguous to the facility within at least 3000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s); and
(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated.

vi. For balloonports, using a scale of one inch equals 100 feet showing:
(1) True north;
(2) Latitude and longitude to the nearest second;
(3) Field elevation (MSL);
(4) Actual dimensions of the departure area;
(5) Location(s) and height(s) (MSL) of any obstructions within a radius of 1000 feet of the center of the proposed facility; and
(6) Facility property lines and municipal boundaries.

vii. For airship bases, using a scale of one inch equals 100 feet showing:
(1) True north;
(2) Latitude and longitude to the nearest second;
(3) Field elevation (MSL);
(4) Actual dimensions of the operating area;
(5) Magnetic alignment of runway(s) to nearest second;
(6) Mast location and airship drift clearance; and
(7) Location(s), use, and height(s), of structures on or proposed for the facility.

viii. For airship bases, using a scale of one inch equals 400 feet showing:
(1) Location(s), use, and height(s) (MSL), of obstruction(s) in the Hazard Zone Area if applicable;
(2) Location(s), use, and height(s) (MSL), of obstruction(s), where Hazard Zoning does not apply, contiguous to the facility within at least 3000 feet from the end of each runway and at least 500 feet from each side of the centerline of the runway(s);
(3) Proposed air traffic patterns superimposed on the drawing with pattern altitudes indicated; and
(4) Mast location and airship drift clearance.

ix. For parachute drop zones, using a scale of one inch equals 400 feet showing:
(1) True north;
(2) Latitude and longitude to the nearest second;
(3) Actual dimensions of the drop zone;
(4) Locations, runway alignments, traffic patterns of any other aeronautical facilities within 5000 feet of the center of the drop zone;
(5) All roads, streets, powerlines, telephone lines, bodies of water where any depth at any time exceeds four feet, within 5000 feet of the center of the drop zone;
(6) All buildings with heights above the drop zone elevation within 5000 feet of the center of the drop zone; and
(7) All inhabited buildings within 5000 feet of the center of the drop zone.

3. Upon request by the Director, submit a narrative legal description, certified by a land surveyor or professional engineer licensed by the State Board of Professional Engineers and Land Surveyors as truly describing the site for which a license is requested or held;

4. If the aeronautical facility premises are not owned by the applicant, the applicant shall:

i. Identify on the license application the owner(s) and any other parties who hold an interest in the property by lease or otherwise, and specify their interest; and

ii. Submit copies of all documents of title or interest to the Office upon request. Prior to licensing, the applicant shall submit written approval for the facility from the person(s) controlling the proposed facility premises;

5. Submit a statement or certificate, issued by the appropriate government body having jurisdiction, that the proposed facility or changes thereto, as submitted in the application, is in conformance or nonconformance with current zoning codes or ordinances; and that according to the plans, it can be constructed in accordance with local building and fire codes. If the relevant government authority does not provide such a statement as to zoning code compliance or noncompliance within 90 days of the date the application was submitted to them for approval, the application shall be considered to be in full compliance with local zoning requirements for the purpose of the licensure application. If the applicant is notified that the proposed facility is contrary to current zoning codes or ordinances, the applicant shall submit to the Office a copy of the application for local approval which has been made and rejected, as well as copies of the certificate or statement of nonconformance, and all relevant provisions of the pertinent ordinances;

6. Submit copies of permit applications or notices of intent which are required by any other Federal, State, or local agency exercising control of designated land or water areas;

7. For deactivation or abandonment, or any change that will require relocation, transfer, or eviction of tenants, submit a plan explaining how facility tenants and or users are to be notified, and what opportunities are available for relocation;

8. Applicants submitting requests under the requirements of N.J.S.A. 16:61 (Safety Fund Grants) are exempt from duplicate DA-1 and 2 requirements; and

9. Submit a completed copy of FAA Form 7480-1 "Notice of Proposed Construction or Alteration" (or subsequent form as amended or superseded) at the same time the form is submitted to the FAA.

16:54-2.2 Application forms for temporary facilities

(a) All persons proposing to operate temporary aeronautical facilities shall:

1. Submit an Application for Temporary Aeronautical Facility, Form DA-5, including all applicable attachments; and

2. Comply with the provisions of N.J.A.C. 16:54-6.

16:54-2.3 Public notice

(a) The applicant shall publish a legal notice as shown in Appendix A, incorporated herein by reference, when required by the Office of Aviation, the text of which will be provided by the Office of Aviation, in at least two newspapers serving the city, township, municipality, county or other political subdivisions.

1. One of the papers shall be the primary one designated by the political subdivision for public notices and the second shall be the newspaper designated as secondary, or, if not so designated, shall be a newspaper circulated widely in that community.

(b) The notice shall contain the text prepared by the Office and shall provide a 30 day period for public comment and response regarding all proposals to construct new aeronautical facilities. At the discretion of the Director, the publication requirements may be waived for a proposed alteration, deactivation or abandonment of an existing facility.

(c) The applicant shall submit certified proof of publication in the two newspapers to the Office of Aviation. Where the publication dates differ, the later publication date will be used by the Office in determining the public period for comment.

16:54-2.4 Public hearing testimony

The applicant shall be prepared to provide relevant data and information regarding the application at a public hearing or at any proceeding requested by the Office of Aviation. Such hearing or proceeding shall be conducted at no cost to the State of New Jersey.

16:54-2.5 Application processing

(a) All applications for aeronautical facility licenses shall be processed by the Office of Aviation to ascertain that the minimum requirements of this chapter are met, as well as whether the issuance of such license considers the interest of public health and safety and the development of aeronautics in the State. Factors such as surrounding land uses, local zoning ordinances, topography, noise characteristics of the type of aeronautical equipment to be used, air traffic patterns proposed in the area, and any other relevant information shall be part of the consideration required for such license processing.

1. The Office of Aviation reserves the right to specify the methods, standards, techniques, and appropriate sites to be used in the construction, changes, modifications, and alterations of new or existing aeronautical facilities sufficient to insure compliance with reasonable engineering practices and to insure the safety of the public.

2. Any proposed changes to an approved application shall be provided to the Director for review and approval before proceeding with the change. Substantive changes, proposed to an already submitted application, which substantially change the impact on the contiguous land area or airspace, cannot be approved and will require the submission of a new application incorporating such changes.

16:54-2.6 Approvals

If the application is approved, the applicant shall receive a license for the facility. If the application is disapproved, the applicant may petition the Commissioner for exemption in accordance with N.J.A.C. 16:54-7, Petition for Exemption.

16:54-2.7 Commencement of activities

No construction, alteration or closure shall commence until the applicant receives written approval from the Director.

16:54-2.8 Renewals

(a) The Department will renew the license only after ensuring the public safety and the safety of those using such licensed aeronautical facilities by:

1. Receiving the proper renewal application form DA-4, Application for License Renewal, and appropriate fee, in accordance with N.J.A.C. 16:54A, at least 15 days prior to the expiration date of the current license; and

2. Completing a satisfactory inspection(s) of the facility conducted or overseen by Office officials, which indicates that all applicable licensing criteria have been met.

(b) Discrepancies noted during an inspection will be reported to the licensee, who shall submit a plan for corrective action, along with a schedule for accomplishing those actions. Renewal of a license may be withheld at the discretion of the Director, pending resolution of discrepancies found during inspection.

(c) If the Director withholds a license renewal pending resolution of discrepancies, the licensee may petition the Commissioner for exemption in accordance with N.J.A.C. 16:54-7, Petitions for exemption.

(d) Any license renewed under this chapter, other than those for temporary facilities, is valid for one year and shall expire on the last day of the 12th month from the month of issuance.

(e) The Director may, at his or her discretion, extend for up to 90 days any license issued by the Office, upon request by the licensee.

16:54-2.9 License Transfers

(a) Aeronautical facility licenses may be transferred under the following conditions:

1. The licensee submits a written request to the Office of Aviation, which includes a letter of intent to transfer ownership or control.

2. Within 30 days of the transfer of ownership or control, the new owner shall submit a signed Form DA-2, Aeronautical Facility Agreement, and proof of legal transfer of ownership or control of the facility.

3. Upon receipt of the documents, the Office will issue an amended license.

4. Failure to comply with the provisions of this section will result in suspension of the facility license, and any operation conducted during such suspension period is illegal.

16:54-2.10 Surrender of license

(a) Licensees which have received approval to deactivate or abandon their facility shall surrender their license to the Office within 30 days after approval of the closure or within 30 days after actual closure, whichever comes later.

(b) Licensees whose license has been suspended or revoked shall immediately surrender their license to the Office or upon demand directly to any duly authorized representative of the Office.

SUBCHAPTER 3. GENERAL REQUIREMENTS

16:54-3.1 General requirements for all aeronautical facilities

(a) All operations at licensed aeronautical facilities shall conform to the Federal Aviation Regulations of the United States, the laws of the State of New Jersey, and the orders and rules promulgated by the Department of Transportation.

(b) All licensed aeronautical facilities shall be maintained in a safe and hazard free condition.

(c) Licensees shall safeguard against encroachment of unauthorized persons on the actual operating area of the aeronautical facility at all times when flights are being conducted, or aircraft are being operated or prepared for operation.

(d) Aircraft capable of meeting FAA certification specifications for landing or take off at a specified size facility shall not be prohibited from using any public use aeronautical facility of that size or greater, except when such use would violate FAA or DOT rules or regulations or would conflict with approved written standard procedures prepared in accordance with this chapter.

(e) Adequate fire fighting equipment and first aid equipment should be available. Written emergency procedures shall be established as required for the category and class of aeronautical facility.

(f) All aircraft accidents occurring on, or contiguous to, any aeronautical facility will be reported by the licensee or his agent as soon as practicable during normal working hours to the Office of Aviation and after hours and on weekends, to the nearest State Police Station. Licensees will notify the FAA of the accident in accordance with the established time requirements set forth in N.J.A.C. 16:61.

(g) Licensees shall provide the Office of Aviation with the current name, home address and telephone numbers of the facility manager or responsible official who may be contacted at any time in case of emergency.

(h) Any duly authorized representative of the Department of Transportation, Office of Aviation, shall be permitted to enter and inspect the premises at any time during scheduled hours of operation. Any such representative shall also be permitted to inspect all records and equipment at any time, upon presentation of proper credentials.

(i) The Certificate of License shall be displayed on the premises at all times, and shall be presented for inspection upon demand of any police officer of this State, or any representative of the Office of Aviation.

(j) If any information found in any license application or any additional information which may be submitted in connection therewith is found to be false, such false statements shall constitute good and sufficient cause for the Commissioner to revoke any license issued based on that application.

16:54-3.2 General requirements for all public use aeronautical facilities

(a) All public use aeronautical facilities shall establish and enforce written standard procedures for all aeronautical activities conducted at their facility. Such activities may include, but are not limited to:

1. Aircraft: sales, charter, rental, lease, storage hangaring, tie-down, and aircraft parking;

2. Instruction: aircraft flight and ground instruction of all types, license examinations and proficiency checks, crew member training, parachute jumping training;

3. Maintenance: all types of maintenance, repair, inspection, testing, modification, overhaul, corrosion control or painting on aircraft, engines, systems, avionics, or ancillary air or ground support equipment;

4. Servicing: aircraft fueling using fixed, hydrant, mobile or portable equipment; aircraft engine or systems servicing including hydraulics, pneumatics, oxygen, lavatory, catering, electronics, aircraft cleaning; and

5. Other usually recognized aeronautical activities, including any activity specifically approved by the Commissioner.

(b) Licensees shall etablish and enforce written general operating procedures to ensure the safety of the general flying public and those using the aeronautical facility.

(c) Prior to implementation, written procedures required in (a) and (b) above shall be reviewed and approved by the Office, as follows. Licensees shall:

1. Notify the Office in writing that such aeronautical activities occur at the facility;

2. Submit copies of the procedures for review; and

3. Open the facility to inspections by any duly authorized representative of the Office during scheduled hours of operation. Office representatives shall also be permitted to inspect all records and equipment. The inspection may include:

i. An evaluation of general compliance with industry standards;

ii. A review of the implementation of the written operating procedures in use or proposed; and/or

iii. A safety inspection of the physical facility.

(d) Licensees shall post, in a conspicuous place at the aeronautical facility, and/or distribute, the approved procedure.

(e) Licensees shall notify the Office of any proposed change to air traffic flight patterns for their facility concurrent with notification to the FAA in accordance with Federal Air Regulation Part 157, and shall receive concurrence from the Office prior to implementing the proposed change.

(f) At public use aeronautical facilities, public use telephones or other means shall be available for emergency service notification (fire, police, rescue) and for contact with FAA air traffic facilities.

16:54-3.3 General requirements for aerospace facilities (Reserved)

16:54-3.4 General requirements for restricted use facilities

(a) Restricted use facilities shall not be open to general public use and shall not be utilized, advertised or represented as such.

(b) The licensee, or his or her designee, shall be responsible for approving the use of the facility by any individual. Approved users shall be advised of facility conditions or restrictions which may affect aircraft operations.

(c) Aeronautical activities may be conducted on restricted facilities upon written request to, and after concurrence by, the Office of Aviation.

SUBCHAPTER 4. (RESERVED)

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. TEMPORARY AERONAUTICAL FACILITIES

16:54-6.1 Temporary licenses

(a) The Office may issue a temporary aeronautical facility license for a special purpose, at a designated area which normally requires no facility preparation, and for a limited period of time which shall not exceed six months.

(b) Temporary licenses may be issued for the following facilities:

1. Airship base;
2. Balloonport;
3. Helistop;
4. Landing strip;
5. Parachute drop zone;
6. Vertiport; and
7. Any other facility as may be designated by the Director.

(c) Temporary licenses issued by the Office shall indicate the following:

1. An expiration date not to exceed six months after the date of issuance;

2. Delineation of approved operations; and

3. All applicable privileges or limitations specified by the Office.

(d) Extensions of temporary licenses may be granted by the Director for a period not to exceed 90 days. Requests for extension may be submitted to the Office of Aviation in writing with an explanation for the request.

(e) A temporary license may be issued for a facility in conjunction with an application for permanent license. Such requests shall be accompanied by written concurrence of the municipality that such use is permitted pending administrative processing of the formal application.

(f) Temporary licenses issued under this rule will become void upon issuance of a permanent license or:

1. If the application for a permanent facility is disapproved by the Department; or

2. One year from date of issuance, if the applicant fails to pursue meeting the requirements of this chapter for a permanent license.

16:54-6.2 Applications

(a) Applications for a temporary facility shall be prepared in compliance with the requirements for a permanent facility of the same type, shall include a completed application Form DA-5, Application for Temporary Aeronautical Facility License, and shall be submitted, and received by the Office of Aviation, at least 10 working days prior to the requested start date. A complete copy of the application and all attachments shall be maintained as part of the applicant's permanent record.

(b) Applications shall include:

1. A letter of approval from the appropriate governing body having jurisdiction, in the form of either a letter of approval signed by the mayor (or a specifically delegated representative), or a certificate or statement issued by the governing body itself;

2. A sketch of the proposed facility which includes the required features, and at the scale specified in N.J.A.C. 16:54-1 for the particular type of facility requested.

i. For banner towing facilities, the sketch shall include the designated drop and "pick-up" area.

ii. For exhibition parachute drop zones, the sketch shall include at least a 200 foot by 200 foot clear target/touchdown area and all obstacles and terrain within 2,500 feet of the center of the target/touchdown area;

3. Certification that the areas to be utilized are under the control of the applicant or are being used with the permission of the landowner;

4. A description of the provisions to be made for the safety of those persons in the immediate vicinity of the operation and those participating in the operations;

5. The name, address, and phone number of the person responsible for the conduct of operations at the proposed facility;

6. Aircraft specifications and performance data indicating that the intended operations can be safely conducted in the areas intended for utilization; and

7. A list of airmen and other persons intending to utilize the facility and their qualifications.

i. A student pilot certificate is not an acceptable minimum airman qualification.

ii. For demonstration or exhibition use of a facility, an applicable FAA Commercial Pilot certificate is the minimum acceptable airman qualification.

iii. For a parachute drop zone, parachutists must hold a U.S. Parachute Association "C" level qualification or better.

(c) Waivers of application requirements for a temporary facility may be requested of the Director.

16:54-6.3 General Requirements for Temporary Aeronautical Facilities (Reserved)

16:54-6.4 Design Standards for Temporary Aeronautical Facilities (Reserved)

16:54-6.5 Operational Standards for Temporary Aeronautical Facilities (Reserved)

SUBCHAPTER 7. PETITIONS FOR EXEMPTION

16:54-7.1 General requirements

(a) Applicants or licensees who believe themselves to be adversely affected by any rules of this chapter, and who believe further that exceptional circumstances or hardship warrant exemption from the rules, may petition the Commissioner.

(b) Petitions for exemption may, but not by way of limitation, take the following form. For engineering or land matters not meeting the criteria of this chapter, the following shall be submitted:

1. A Form DA-1 (with all the attachments required by N.J.A.C. 16:54-2.1) marked, "petition for exemption"; and

2. A complete description of, and reasoning for, the proposed departure from the criteria of this chapter, entitled "Petition for exemption."

(c) Petitions for exemption not lending themselves to a DA-1 submission form may, but not by way of limitation, take the following form.

1. The applicant shall submit all relevant data relating to, including a complete description and reasoning, for the proposed departure from the criteria of this chapter with submissions marked, petition for exemption.

(d) Petitions shall be filed with the Director of Aviation. The Director will forward the petition for exemption, along with his or her recommendations, to the Commissioner within 15 working days of receipt of petition. Time for petition evaluation may be further extended by the Commissioner, for good cause.

(e) The approval or disapproval of a petition for exemption shall be determined by the Commissioner of Transportation after the evaluation of the essential information submitted by the applicant and made available from all other sources. Under some circumstances, the Commissioner may deem it necessary to hold a public hearing on the matters contained in a petition for exemption.

SUBCHAPTER 8. LIABILITY AND PENALTY

16:54-8.1 General provisions relating to liability and penalty

(a) Any license issued pursuant to the provisions set forth in this chapter does not waive any Federal rules or regulations or burden of compliance with FAA Advisory Circulars relating to Aviation. Furthermore, any license issued pursuant to the provisions set forth in this chapter may be modified, suspended, or revoked in the interest of public safety or as a result of an established violation of any of the provisions of this chapter and/or any of the provisions of Title 6 of the New Jersey Statutes.

(b) Any person who makes a misrepresentation or false statement in any application, interview, or submission of information to the Office of Aviation is acting contrary to the provisions of this chapter and Title 6 of the New Jersey Statutes.

(c) Any application which is found to contain misrepresentations or false statements shall be rejected and any license issued as a result of that application shall be immediately suspended, pending submission of a corrected application. If corrections are not made within 30 days, the Director may revoke the suspended license.

(d) Any person who allows, permits, or otherwise knowingly aids and abets the unlicensed or improperly licensed operation of an aeronautical facility, or any other activities or conditions that are contrary to the provisions of this chapter or Title 6 of the New Jersey Statutes is acting contrary to the provisions of this chapter or title. Persons acting contrary to this chapter or Title 6 shall be subject to the fines and penalties as provided by Title 6 of the New Jersey Statutes.

SUBCHAPTER 9. SUSPENSIONS AND REVOCATIONS

16:54-9.1 Suspensions (Reserved)

16:54-9.2 Revocations (Reserved)

16:54-9.3 Appeals (Reserved)

SUBCHAPTER 10. POWERS

16:54-10.1 Authority

Licensing requirements shall not be construed as limiting in any way the power of the Commissioner in regulating the operation of airports or other aeronautical facilities. Decisions regarding denial, issuance, or renewal of licenses are within the purview of, and shall ultimately be determined by, the Commissioner.

APPENDIX A

PUBLIC NOTICE

Notice of Proposed Aeronautical Facility Licensing

ALL INTERESTED PERSONS are hereby advised that the Office of Aviation, of the New Jersey Department of Transportation, has received an application from _____

for a license to establish a _____

at _____

Accordingly, the Office of Aviation invites written comments or objections regarding this proposed license. All comments or objections must address the issue of the effect of the proposed license upon the public health and safety.

Upon receipt of written comments or objections, and a determination by the Office of Aviation that the proposed licensing is a "contested case", as defined by N.J.S.A. 52:14B-1 et seq., this matter may be scheduled for a public hearing.

The above-named application and all related documents are available for public inspection by appointment between the hours of 9:00 A.M. and 4:00 P.M. at the Office of Aviation, New Jersey Department of Transportation, 1035 Parkway Avenue, Trenton, New Jersey, Telephone (609) 530-2908.

Any interested persons may submit questions or comments, in writing, no later than 30 days from today.

All submissions regarding this matter should be directed to:

Office of Community Involvement
New Jersey Department of Transportation
1035 Parkway Avenue, CN 600
Trenton, New Jersey 08625

RULE ADOPTIONS

ADMINISTRATIVE LAW

(a)

OFFICE OF ADMINISTRATIVE LAW

Uniform Administrative Procedure Rules
Discipline of Administrative Law Judges
Adopted New Rules: N.J.A.C. 1:31-3

Proposed: October 7, 1991 at 23 N.J.R. 2901(a).
Adopted: December 10, 1991 by Jaynee LaVecchia, Director, Office of Administrative Law.
Filed: December 10, 1991 as R.1992 d.17, **without change.**

Authority: N.J.S.A. 52:14F-5(e), (f) and (g).

Effective Date: January 6, 1992.
Expiration Date: June 17, 1992.

Summary of Public Comments and Agency Responses:

The Executive Commission on Ethical Standards raised a concern that the proposed rules might be construed as giving the Director of the Office of Administrative Law (OAL) the power to discipline an administrative law judge for a violation of the New Jersey Conflicts of Interest Law, N.J.S.A. 52:13D-23(d), without referral to or the approval of the Ethics Commission.

OAL concurs that the Ethics Commission has undisputed jurisdiction to determine matters under the Conflicts of Interest Law and does not intend through this disciplinary process for administrative law judges to infringe upon this jurisdiction. The rules are intended to set forth the process and causes for disciplining administrative law judges. Some confusion may have been generated by N.J.A.C. 1:31-3.1(a)4 which provides that a judge may be disciplined for any conduct which violates the Code of Judicial Conduct as made applicable to administrative law judges by OAL Code of Ethics. OAL does not intend by this provision to assert jurisdiction over all matters arising under the Conflicts of Interest Law. The Code of Ethics is the mechanism by which the standards of conduct embodied in the Code of Judicial Conduct, such as those governing diligence, demeanor and impartiality, apply to administrative law judges. OAL believes that violations of those standards by an administrative law judge are appropriate for disciplinary action by this office. It has long been recognized that an agency is free to take disciplinary action unencumbered by the separate jurisdiction of the Ethics Commission to consider a matter which might constitute misconduct.

This matter was discussed with the Ethics Commission's Acting Executive Director; a comment from that agency received subsequently does not express an objection to this rule as interpreted above. The Acting Executive Director of the Commission reiterated the joint understanding between OAL and the Commission that any action for discipline for a violation of the conflicts of interest law shall only be undertaken upon the referral or with the approval of the Executive Commission on Ethical Standards.

The OAL will be codifying in a proposal issuing shortly rules of judicial conduct for administrative law judges. This proposal will eliminate any misconception caused by the current incorporation of the Judicial Canons through the OAL Code of Ethics instead of through a rule promulgation. Therefore, the OAL does not believe that any change in the rules as proposed is warranted at this time.

Full text of the adoption follows.

SUBCHAPTER 3. DISCIPLINE OF ADMINISTRATIVE LAW JUDGES

1:31-3.1 General causes for discipline

(a) The Director of the Office of Administrative Law may discipline an administrative law judge for:

1. Willful misconduct including misconduct which, although not directly pertaining to judicial duties, brings the office into disrepute or is prejudicial to the administration of justice;

2. Willful, persistent, or negligent failure of a judge to perform judicial duties, including incompetent performance of judicial duties;

3. Intemperance, including injudicious personal conduct, recurring loss of temper or control, abuse of alcohol, or the abuse of controlled dangerous substances;

4. Any conduct which constitutes a violation of the OAL Office Policies for Administrative Law Judges or the Code of Judicial Conduct, Appendix to Part 1, Pressler, Current N.J. Court Rules (1991), as made applicable by Sec. IV(6) of the OAL Code of Ethics; or

5. Other sufficient cause.

1:31-3.2 Complaints and forms of discipline

(a) Upon becoming aware of any circumstance, statement, criticism, or complaint, which is not obviously unfounded or frivolous, which does not relate solely to a matter subject to an appeal, and which indicates that an administrative law judge has committed any conduct described in N.J.A.C. 1:31-3.1, the Director may initiate proceedings to impose disciplinary sanctions. Such sanctions shall include, but not be limited to:

1. The issuance of a private reprimand;
2. The issuance of a public reprimand;
3. The imposition of a fine;
4. A suspension of up to six months; or
5. A recommendation to the Governor for removal, pursuant to Art. V, Sec. IV, Par. 5 of the New Jersey Constitution.

1:31-3.3 Minor discipline

When the Director seeks to impose a written or oral reprimand, public or private, an administrative law judge shall receive formal notification of the charges and shall be afforded an opportunity to review the charges and to respond to the Director either orally or in writing. No formal hearing will be provided. The notice to the judge shall specify in ordinary and concise language the charges against the judge and the alleged facts upon which they are based. The decision of the Director shall be final.

1:31-3.4 Penalty beyond reprimand

When the Director believes that a penalty greater than an oral or written reprimand may be appropriate, the Director may forward the matter to the Office of Administrative Law Advisory Committee on Judicial Conduct or issue a formal complaint and order in accordance with N.J.A.C. 1:31-3.8.

1:31-3.5 Establishment of OAL Advisory Committee on Judicial Conduct

(a) There is established an OAL Advisory Committee on Judicial Conduct to investigate complaints referred by the Director concerning judicial conduct and to give advisory opinions, recommendations, and reports to the Director of the Office of Administrative Law. The Committee shall consist of three members who shall be appointed by the Director for terms expiring respectively one, two, and three years after appointment, whose respective successors shall be appointed upon the expiration of such terms and annually thereafter to serve three-year terms. A Committee member may be reappointed at the discretion of the Director. The Director may appoint any administrative law judge to serve as a member of the Committee. If willing to serve, retired administrative law judges or retired judges of the Superior Court of New Jersey may be eligible for appointment to the Committee at the discretion of the Director. The Director shall appoint one member to serve as Chairperson. All appointments to fill vacancies shall be for the unexpired term.

(b) No action of the Committee shall be valid unless concurred to by a majority of its membership.

(c) An employee of OAL designated by the Director will serve as secretary to the Committee.

(d) The Committee shall be provided with clerical and administrative assistance as may be needed to perform its function. If a criminal investigation is required, the matter shall be referred to the Attorney General.

(e) All papers filed with and proceedings before the Committee shall be confidential.

1:31-3.6 Preliminary investigation

(a) The Committee shall conduct a preliminary investigation at the request of the Director. To perform a preliminary investigation, the Committee may utilize the following methods:

1. It may request that the Director provide sufficient resources to conduct an investigation of the matter.

2. Unless the circumstances render it unnecessary or inappropriate, the Committee may require the complainant to file with the Committee a statement signed under oath against the judge.

3. The Committee shall notify the judge of the nature of the charge, the name of the person making it where appropriate, and that the judge has the opportunity to present within such reasonable time as the Committee shall fix, such matters as the judge may choose with respect to it. This includes the right to appear before the Committee, with or without counsel, and to make a statement under oath as the judge deems appropriate. If deemed appropriate, the Committee may request that the complainant make a supplemental statement under oath. These statements, if oral, shall be sound recorded.

4. The notice to the judge shall specify in ordinary and concise language the charges against the judge and the alleged facts upon which they are based.

1:31-3.7 Recommendations of the Committee

(a) Upon completion of the preliminary investigation, the Committee may take any of the following actions which may be accepted, rejected, or modified by the Director:

1. The Committee may recommend that the Director dismiss the charges and notify the parties of the action taken. If the matter has been made public, the Director may, at the request of the judge involved, issue a short statement of clarification and correction.

2. If the investigation reveals some departures by the judge from common standards of judicial propriety, such as discourtesy, rudeness, disparagement of witnesses or attorneys, and the like, or other conduct or demeanor which would reflect unfavorably upon the administration of justice if persisted in or were to become habitual or more substantial in character, the Committee may request the judge to appear at a time and place designated for an informal discussion of the matter. After making the judge aware of the objectionable conduct, and becoming satisfied that it was temporary in nature and not likely to become habitual, the Committee may recommend to the Director that the complaint be dismissed and the parties advised of the action taken, and the reasons therefor. Any such conference shall be recorded by a sound recording device and a transcribed record of the tape filed with the papers in the proceeding.

3. If the Committee believes that the judge may be suffering from a mental or physical disability which is disabling the judge and may continue to disable the judge indefinitely or permanently from the performance of his or her duties, it shall recommend to the Director an appropriate response that balances any medical need of the judge and protects the public interest.

4. Whenever the Committee concludes from the preliminary investigation that the circumstances merit an oral or written reprimand, the Committee shall promptly file a copy of the recommendation, and the record of the Committee certified as such by its secretary, with the Director. If the Director agrees with the recommendation, the Director shall proceed in accordance with N.J.A.C. 1:31-3.3. If the Director disagrees with the recommendation, the Director may issue a formal complaint and order in accordance with N.J.A.C. 1:31-3.8.

5. Whenever the Committee concludes from the preliminary investigation that the circumstances, if established at an evidentiary hearing, merit disciplinary action greater than an oral or written reprimand, and that formal proceedings to that end should be instituted, the Committee shall promptly file a copy of the recommendation and the record of the Committee certified as such by its secretary with the Director. The Committee shall issue also without delay and serve upon the judge a notice advising him or her that it has filed such a recommendation with the Director.

1:31-3.8 Issuance of order

Upon receipt and review of any opinions, recommendations, and reports from the Committee under N.J.A.C. 1:31-3.7(e), the Director may proceed in accordance with N.J.A.C. 1:31-3.3 or may issue a formal complaint and order the judge to show cause why a specific sanction should not be imposed or a recommendation for removal not be sent to the Governor. The order to show cause shall require the judge to answer the complaint within 30 days of service of the complaint and order upon the judge.

1:31-3.9 Formal hearing

Unless the judge's answer to the complaint renders further formal proceedings unnecessary, a due process hearing shall be conducted by a designee of the Director. The evidentiary hearing in this matter shall begin within 30 days from the filing of the answer with the OAL. At the hearing, the OAL will be represented by the secretary to the Committee or the Director may request representation from the Office of the Attorney General. The decision of the designated hearer shall be a recommendation to the Director. The Director shall make the final decision in the matter within 10 days unless notice is provided to the judge that the time for review needs to be extended.

1:31-3.10 Confidentiality

The record before the OAL Advisory Committee shall be confidential and shall not be available to any person except in the proper discharge of official duties, unless the judge requests that the charge, proceedings, and action shall be made public. If a public reprimand is imposed by the Director, the written reprimand shall be made public. Upon the issuance of a complaint and order to show cause, the complaint and order shall be made public. The entire record shall, unless the Director otherwise orders, be made public upon the entry of a final order imposing a fine, suspension, or removal.

1:31-3.11 Judicial independence and discipline process

The methods used by the judge, but not the result arrived at by the judge in any case, may be the cause for discipline of the judge. In order to foster and encourage judicial independence, claims of error shall be left to appellate review and not be subject to discipline.

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Fire Code
Certificate of Smoke Detector Compliance
Adopted Amendments: N.J.A.C. 5:18-2.8, 3.2 and 4.3
Adopted New Rules: N.J.A.C. 5:18-2.20 and 4.19

Proposed: October 21, 1991 at 23 N.J.R. 3064(a).
Adopted: December 2, 1991 by Melvin R. Primas, Jr., Commissioner, Department of Community Affairs.
Filed: December 5, 1991 as R.1992 d.11, **with substantive and technical changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: P.L. 1991, c.92.

Effective Date: January 6, 1992.
Expiration Date: January 4, 1995.

Summary of Public Comments and Agency Responses:

Comments were received from Susan McGuinness, Director of Governmental Affairs of the New Jersey Association of Realtors (NJAR), and from Andy Cattano, Director of Technical Services of the New Jersey Builders Association (NJBA).

COMMENT: NJAR generally supports the proposed rules and views them as "clearing up the confusion that has resulted in the disruption of many real estate transactions in many municipalities." However, NJAR is concerned about the limitation to seasonal rentals of the provision allowing 12-month certificates in lieu of a new certificate each time occupancy changes and believes that this provision should apply to all rentals.

RESPONSE: Seasonal rentals of one and two-family houses are more like a hotel use than a normal residential use. The occupants have their homes elsewhere and changes of occupancy are typically so frequent that requiring an inspection on each occasion would be unduly burdensome. An ordinary house rental, however, is still the rental of a primary residence, even if the tenant leaves in less than a year. The tenant who moves in after a tenant who has lived in the house for less than a year is entitled to the protection that this legislation is intended to provide, protection that can be provided without the undue burden that would exist in the case of a seasonal, hotel-type occupancy.

COMMENT: NJAR believes that it should be clearly stated that "only a municipality which has no property maintenance ordinance may forego an inspection and use a certificate signed by the seller or their representative."

RESPONSE: As was indicated in the proposal Summary, the alternative of a certification in lieu of inspection is intended to apply to those cases in which the fire official, rather than a local code enforcement official, is responsible for issuing the certificate of smoke detector compliance. There is no need for the certification provision when the unit is already being inspected under a local ordinance. The rule is therefore being revised upon adoption to make this clear.

COMMENT: NJBA believes that it should be made clear that new construction is not subject to this rule because a new building must comply with smoke detector requirements in order to get a certificate of occupancy under the Uniform Construction Code.

RESPONSE: The statute and the rule are applicable only to a "change of occupancy." An initial occupancy is not a change of occupancy. The rule has been revised upon adoption to make this clear.

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

5:18-2.8 Fees: registration, certificate of smoke detector compliance and permit

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

(d) The application fee for a certificate of smoke detector compliance, as required by N.J.A.C. 5:18-2.20, shall be $20.00.

(e) A municipality having a local enforcing agency may establish by ordinance a different permit and certificate of smoke detector compliance fee schedule based on the actual cost anticipated or incurred for the enforcement of these Code provisions.

5:18-2.20 Certificate of smoke detector compliance

(a) Before any Use Group R-3 structure is sold, leased, or otherwise ***made*** subject to a change of occupancy for residential purposes, the owner shall obtain a certificate of smoke detector compliance (CSDC), evidencing compliance with N.J.A.C. 5:18-4.19, from the appropriate enforcing agency.

1. Where a municipality has existing inspection or approval requirements under a property maintenance or other municipal code, the agency responsible for the enforcement of that code shall not issue any certificate of inspection or occupancy or other approval under such municipal code until it has determined, in accordance with (d) below, that the dwelling complies with the requirements of N.J.A.C. 5:18-4.19.

2. Where no municipal inspection or approval requirement exists, the agency responsible for enforcement of the Uniform Fire Safety Act shall be responsible for the issuance of the CSDC.

(b) The owner, or the authorized agent of the owner, shall apply for a CSDC on a form provided by the enforcing agency. The application shall be accompanied by the appropriate fee as set forth in N.J.A.C. 5:18-2.8.

(c) A CSDC shall not be transferable. If the change of occupancy specified in the application for a CSDC does not occur within six months, a new application shall be required.

1. The enforcing agency may issue a CSDC for a seasonal rental unit for a period of up to 12 months, regardless of the number or frequency of changes in tenancy.

(d) No CSDC shall be issued until inspection of the structure indicates compliance with N.J.A.C. 5:18-4.19.

1. The *[local]* enforcing agency***, unless it is otherwise required to inspect the structure under a property maintenance or other municipal code,*** may accept, in lieu of inspection, a certification that one or more smoke detectors, as applicable, have been installed and tested in accordance with N.J.A.C. 5:18-4.19. Such certification shall be upon forms provided by the enforcing agency.

5:18-3.2 Modifications

(a) The following articles or sections of the State Fire Prevention Code are modified as follows:

1.-33. (No change.)

34. Appendix A (Referenced Standards) A.N.S.I. (American National Standards Institute, Inc.) is amended as follows:

i. Add Standard Reference Number UL 217, Single and Multiple Station Smoke Detectors, referenced in N.J.A.C. 5:18-4.19(c).

35. (No change in text.)

5:18-4.3 Relation to Uniform Construction Code and other Codes

(a) A building in full compliance with the subcodes adopted pursuant to the Uniform Construction Code Act and regulations in force at the time of its construction and possessing a valid certificate of occupancy shall not be required to conform to the more restrictive requirements established by this subchapter.

1. Exception: The requirements of N.J.A.C. 5:18-4.19 shall apply to all Use Group R-3 structures ***other than newly-constructed buildings at the time of initial occupancy***, regardless of their state of compliance with the Uniform Construction Code or any other code.

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

(d) A variation previously granted to a provision of an existing code, which provision contains requirements substantially the same as the comparable provision of the Uniform Fire Code, shall remain valid, subject to the following conditions:

1. (No change.)

(e) Notwithstanding the provisions of (a) through (d) above, nothing shall prevent the fire official from making a finding of imminent hazard pursuant to N.J.A.C. 5:18-2.14 or the construction official from making a finding of unsafe building pursuant to N.J.A.C. 5:23-2.23 and requiring correction of such hazard or unsafe condition in accordance with those regulations.

5:18-4.19 Smoke detectors for one and two-family dwellings

(a) In all Use Group R-3 dwellings subject to the requirements of N.J.A.C. 5:18-2.20, smoke detectors shall be installed as follows:

1. On each level of the premises; and

2. Outside of each separate sleeping area.

(b) The smoke detectors required in (a) above shall be located in accordance with NFPA 74 and maintained in working order.

1. The detectors shall not be required to be interconnected.

(c) Smoke detectors may be battery-powered and shall be listed in accordance with ANSI/UL 217.

1. A/C-powered smoke detectors shall be accepted as meeting the requirements of this section.

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Fire Code

Identifying Emblems for Structures with Truss Construction

Adopted New Rule: N.J.A.C. 5:18-2.19

Proposed: September 3, 1991 at 23 N.J.R. 2618(a).
Adopted: November 25, 1991 by Melvin R. Primas, Jr., Commissioner, Department of Community Affairs.
Filed: December 2, 1991 as R.1992 d.5, **without change.**

Authority: N.J.S.A. 52:27D-198; P.L. 1991, c.188.

Effective Date: January 6, 1992.
Expiration Date: January 4, 1995.

Summary of Public Comments and Agency Responses:

Comments were received from Christopher G. Dudek, P.E. and from Craig A. Peterson, Fire Official of Fire District 4, Old Bridge Township.

Mr. Dudek asks for a definition of "truss" that would limit the applicability of the rule to those large, non-redundant trusses that con-

stitute a special hazard to firefighters. He states that "common truss-like construction," be it bar joists, plate connected wood trusses, or wood-metal composite systems, is "as safe as, if not safer than, conventional building" and that "posting all truss-type buildings would result in a dilution of the effect of the warning, and would only disguise those buildings where a real hazard exists."

In response, the Department states that it shares Mr. Dudek's concerns but that P.L. 1991, c.188 is written in such a way that it leaves the Department no discretion to limit the applicability of the statute to certain types of truss construction. This is a defect that should be corrected, but the remedy is with the Legislature.

Mr. Peterson recommends improvements in the design of the warning emblem required to be posted on buildings with truss construction. He suggests that the Department, in its rule, offer a "counter-proposal" to the design mandated by P.L. 1991, c.188.

The response to Mr. Peterson is essentially the same as the response to Mr. Dudek. While there may be good reason to have a different design for the emblem required to be posted, the statute gives the Department no discretion whatsoever to vary the design. Again, the remedy is with the Legislature.

Full text of the adoption follows.

5:18-2.19 Identifying emblems for structures with truss construction

(a) Identifying emblems shall be permanently affixed to the front of structures with truss construction.

1. The emblem shall be of a bright and reflective color, or made of reflective material. The shape of the emblem shall be an isosceles triangle and the size shall be 12 inches horizontally by six inches vertically. The following letters, of a size and color to make them conspicuous, shall be printed on the emblem:

i. "F" to signify a floor with truss construction;

ii. "R" to signify a roof with truss construction; or

iii. "F/R" to signify both a floor and roof with truss construction.

2. The emblem shall be permanently affixed to the left of the main entrance door at a height between four and six feet above the ground and shall be installed and maintained by the owner of the building.

(b) Detached one and two family residential structures with truss construction that are not part of a planned real estate development shall be exempt from the requirements of (a) above, unless otherwise provided by municipal ordinance.

(c) Individual structures and dwelling units with truss construction that are part of a planned real estate development shall not be required to have an identifying emblem if there is an emblem affixed at each entrance to the development.

EDUCATION

(a)

THE COMMISSIONER

Organization of the Department of Education Organizational Structure; Personnel: Method of Operations

Adopted Amendments: N.J.A.C. 6:5-2.1 and 2.2

Adopted: December 4, 1991 by John Ellis, Commissioner, Department of Education.

Filed: December 10, 1991 as R.1992 d.21.

Authority: N.J.S.A. 52:14B-3(1).

Effective Date: December 10, 1991.

Expiration Date: October 22, 1995.

These proposed amendments are organizational in nature and, as such, in accordance with N.J.S.A. 52:14B-4(b), may be adopted without prior notice or hearing and are effective upon filing.

Full text of the adoption follows.

SUBCHAPTER 2. ORGANIZATION OF THE DEPARTMENT

6:5-2.1 Organizational structure

The Commissioner of Education shall develop and present to the State Board of Education for its approval an organizational chart which includes all divisions of the Department of Education and all other units for which managerial appointments require State Board approval pursuant to N.J.A.C. 6:5-2.2. This chart shall be published in the New Jersey Register and incorporated in the Administrative Code pursuant to N.J.S.A. 52:14B-4(b).

6:5-2.2 Personnel: Method of Operations

(a) The Commissioner shall appoint, subject to the approval of the State Board, each assistant commissioner, the senior manager for each division of the Department, each county and State district superintendent, the superintendent of the State School for the Deaf, and the managers of those offices that coordinate board meetings and process state board appeals.

(b) All other personnel appointments shall be made by the Commissioner subject to the notification procedure in (c) below.

(c) The Commissioner shall regularly report to the Board as to all appointments and removals including resignations, transfers, and vacancies. The Commissioner shall also report to the Board as to any acting appointments that he or she has made for the positions specified in (a) above. An acting appointment made pursuant to N.J.S.A. 18A:7-2 shall be made subject to the requisite State Board approval. In the event an acting appointment to one of the positions specified in (a) above continues for more than 60 days, the Commissioner shall report to the State Board on the progress toward filling that position on a permanent basis.

(d) In cases where the Commissioner's personnel actions affect the organizational chart or the fulfillment of regulatory requirements, the Commissioner shall advise the Board of such implications and of actions required for resolution.

Recodify existing N.J.A.C. 6:5-2.1-2.3 as **6:5-2.3-2.5** (No change in text.)

(b)

STATE BOARD OF EDUCATION

Thorough and Efficient System of Free Public Schools

Readoption with Amendments: N.J.A.C. 6:8 Adopted Repeal: N.J.A.C. 6:8-8

Proposed: October 7, 1991 at 23 N.J.R. 2908(b).

Adopted: December 4, 1991 by State Board of Education, John Ellis, Secretary, State Board of Education and Commissioner, Department of Education.

Filed: December 11, 1991 as R.1991 d.22, **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. 18A:1-1, 18A:4-15, as supplemented and amended by N.J.S.A. 18A:7A-1 et seq., P.L. 1990, c.52, P.L. 1991, c.3 and P.L. 1991, c.62.

Effective Date: December 11, 1991, Readoption; January 6, 1992, Amendments and Repeal.

Expiration Date: December 11, 1996.

Summary of Public Comments and Agency Responses:

Seven letters of comment were received. Two letters came from the same commenter. One person spoke at the October 16, 1991 public testimony session held by the State Board of Education.

Written comments were received from the following:

Jean Paashaus, Summit, N.J.

Ann Averbach, President, The League of Women Voters

Mathew R. Glowski, Chief School Administrator, Alpine School District

Marilyn J. Moreheuser, Executive Director, Education Law Centers, Inc.

Robert E. Boose, Executive Director, N.J. School Boards Association
Herbert Frederick, Chair, Fine and Practical Arts, Wildwood High School

Speaker at the October 16, 1991 public testimony session:
Joan Policastro, President, Alliance for Arts Education in N.J.

COMMENT: Three letters of comment raised concern over the fact that the proposed amendments to N.J.A.C. 6:8 only require remediation in the basic skills and define at-risk pupils and programs for at-risk pupils too narrowly. These same three commenters have requested that the State Board of Education reject the proposed rules and require the Department of Education to prepare new proposals consistent with the Supreme Court decision in *Abbott v. Burke* and the Quality Education Act of 1990. Two commenters raised questions concerning the definitions of "at-risk pupil" and "preventive and remedial programs" and the necessity of certain words and phrases contained therein.

RESPONSE: The Department has reviewed these comments and intends to propose amendments to this chapter. The amendments which will be proposed will be based on: (1) the outcome of the Commissioner's charge, as required in P.L. 1991, c.259, to study the criteria or method of identifying students that have special disadvantages and to identify the requisite programs and services for these students, as well as the costs associated with the programs; and (2) the findings and recommendations of the State Task Force on Educational Assessment and Monitoring. This task force was appointed in accordance with P.L. 1991, c.3 and is charged with reviewing the Statewide system for evaluating the performance of each school to determine the State performance standards that would most effectively achieve the legislative goal of a thorough and efficient system of free public schools establishing new standards for the evaluation of school districts. The new monitoring statute also requires the State Board to adopt new rules by December, 1992. Therefore, the amendments to N.J.A.C. 6:8-1.1 and 6:8-6 are only interim in nature and will allow districts to use existing systems to begin to implement the Quality Education Act of 1990. Thus, the State Board of Education has adopted the proposal as it was published in the October 7, 1991 issue of the New Jersey Register.

COMMENT: Two commenters note that no action is being taken on the high school graduation requirements at this time. However, they have requested that the Department include the public in the administrative process for these rules once they begin.

RESPONSE: The Department feels it would be premature to make changes in the current high school graduation requirements. Amendments to these rules will be proposed upon the completion of the Commissioner's study of student needs and programs to address these needs, as required by P.L. 1991, c.259, and based on the findings and recommendations of the State Task Force on Educational Assessment and Monitoring, as specified in P.L. 1991, c.3.

Additionally, the Department of Education's rulemaking process allows for two public testimony sessions and a 30-day comment period. Upon the presentation of the new rules pursuant to P.L. 1991, c.3 which would include the high school graduation requirements, the commenters may provide input through the Department's regular rulemaking process.

Summary of Agency Initiated Changes Upon Adoption:

The Department is correcting the evaluation time frame from five to seven years in the definition of "monitoring" found at N.J.A.C. 6:8-1.1. This is being done in order to bring the definition into conformity with the amendment that was proposed and is now being adopted to N.J.A.C. 6:8-4.1(d).

At N.J.A.C. 6:8-5.2(b), the agency changed "(b)" to "(c)" to correct a typographical error.

At N.J.A.C. 6:8-7.1(c)2iii, the agency changed "local school districts" to "district boards of education" for consistency. Throughout this chapter, the term "district boards of education" is used.

Full text of the adoption may be found in the New Jersey Administrative Code at N.J.A.C. 6:8.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*).

6:8-1.1 Words and phrases defined

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

...

"At risk pupil" means a pupil who is in danger of failure or dropping out of school because of specific cognitive, affective, economic, social and/or health needs.

"Basic Skills Improvement (BSI) Plan" means a plan submitted by districts to the department which outlines the provisions of services to all pupils in need of assistance in reading, writing and mathematics skills.

...

"Monitoring" means the process whereby the Commissioner of Education evaluates the status of each school district every *[five]* ***seven*** years for the purpose of certification. Monitoring also pertains to any evaluation of school districts by the New Jersey State Department of Education.

...

"Preventive and remedial program" means any supplemental program which is designed to prevent regression and to improve the level of pupil proficiency in the areas of reading, writing, and mathematics or related services. These may be programs offered during the normal school day or programs offered beyond the normal school day or during summer vacation which are integrated and coordinated with programs operated during the regular school day and year for students below the State minimum levels of proficiency. A preventive and remedial program is one example of a program for at-risk pupils.

"Preventive and remedial pupil" means a pupil who is enrolled in an approved preventive and/or remedial program, and who:

1. Is in grades K through 2 and does not meet locally established, State-approved standards of proficiency in reading, writing, and/or mathematics; or

2. Is in grades 3 through 12 and does not meet the State minimum levels of pupil proficiency in reading, writing, and/or mathematics.

...

"Program for at-risk pupils" means a program, including early intervention and/or prevention strategies, which addresses the factors which put a pupil at-risk of failure or dropping out of school. Students served by such a program are those in danger of not acquiring the knowledge, skills, behaviors and attitudes necessary for school success, school completion, and successful functioning as an adult in society because of specific cognitive, affective, economic, social and/or health needs.

...

6:8-2.2 State educational standards

The State educational standards shall be those set forth in N.J.A.C. 6:8-4.2 which shall be used for the implementation of a thorough and efficient system of free public schools in accordance with N.J.S.A. 18A:7A-1 et seq. and the New Jersey Constitution.

SUBCHAPTER 4. INTERIM RULES FOR THE EVALUATION OF THE PERFORMANCE OF EACH PUBLIC SCHOOL DISTRICT

6:8-4.1 General requirements

(a) This subchapter shall apply to each school district not currently certified.

1. Any district that failed to become certified shall be required to take corrective action as described in N.J.A.C. 6:8-5.

2. The corrective action shall address deficiencies identified during monitoring of the elements and standards described in N.J.A.C. 6:8-4.2.

(b) This subchapter shall become operative January 1, 1992 and expire June 30, 1993.

(c) (No change.)

(d) A district certified pursuant to this chapter shall not be required to be formally evaluated for seven years.

(e) The Commissioner reserves the right to recommend that the State Board of Education rescind the certification of any district which may fall into noncompliance with the standards set forth in this chapter.

6:8-4.2 Evaluation of elements and standards

(a) The following 10 essential elements and the prescribed indicators of standards of acceptable performance shall be evaluated

by the monitoring team under the supervision of the county superintendent of schools as specified in this section.

1. The annual educational planning element of the district shall be rated acceptable upon demonstration of performance in three indicators as follows:

i. (No change.)

ii. Three or more written educational objectives, which shall include standards of pupil achievement and action plans based upon district needs, shall be developed annually in consultation with teaching staff members and the community under the direction of the chief school administrator in accordance with requirements established by the Commissioner.

(1)-(3) (No change.)

iii. A long-range plan containing a five-year written schedule and procedure for evaluation and improvement of all curriculum and educational services shall be developed and implemented.

2. (No change.)

3. The comprehensive curriculum and instruction element of the district shall be rated acceptable upon documentation of performance in seven indicators as follows:

i. The district board of education shall approve annually a curriculum for all grades from pre-kindergarten through grade 12 for all subjects including all State-mandated programs and services.

(1)-(2) (No change.)

(3) In accordance with N.J.A.C. 6:8-7.1(c)2iii and N.J.A.C. 6:39-1.3(b), district boards of education shall provide for:

(A)-(B) (No change.)

(C) Annual assessment of all students in those proficiencies necessary to meet all State and local high school graduation requirements.

ii.-vii. (No change.)

4.-6. (No change.)

7. The mandated programs element of the district shall be rated acceptable upon documentation of performance in three indicators as follows:

i. The district shall implement a basic skills improvement plan pursuant to N.J.A.C. 6:8-6.2.

(1)-(2) (No change.)

ii.-iii. (No change.)

8. The mandated basic skills test element of the district shall be rated acceptable upon documentation of achievement in two indicators as follows:

i. Seventy-five percent of the pupils in grade nine of each school shall have passed the State-mandated High School Proficiency Test pursuant to N.J.A.C. 6:39-1.2(a) and (b).

ii. (No change.)

9. The equal educational opportunity and affirmative action element of the district shall be rated acceptable by documentation of performance in three indicators as follows:

i. (No change.)

ii. Annually, the district shall review progress toward the objectives of the State-approved affirmative action plans for classroom and employment practices of the district.

iii. (No change.)

10. (No change.)

6:8-4.3 Findings

(a) The monitoring team shall record its findings on each element required by this chapter, using worksheets prescribed by the Commissioner of Education.

1.-2. (No change.)

3. The notification shall include:

i. (No change.)

ii. A copy of the recommendation to the Commissioner of the certification status of the districts; and

iii. (No change.)

4. (No change.)

6:8-4.4 Certification

(a) Certification of a district shall be based on an acceptable rating of all indicators in the 10 essential elements required by this chapter.

1. For each district that receives an acceptable rating on all indicators in the 10 essential elements, the county superintendent of schools shall submit a recommendation for certification and a summary report of the findings to the Commissioner of Education. The Commissioner, with approval of the State Board of Education, shall notify the district of State certification.

2. (No change.)

(b) (No change.)

SUBCHAPTER 5. INTERIM RULES FOR LEVEL II AND LEVEL III DISTRICTS

6:8-5.1 Determination of Level II districts

(a) When a district does not meet the required standards of the evaluation of school districts pursuant to N.J.A.C. 6:8-4, the county superintendent of schools shall meet with the chief school administrator and board secretary to review the identified deficiency(ies) and determine if the district can correct the identified deficiency(ies) without additional diagnostic monitoring or technical assistance within a period of time not to exceed 12 months, or should be directed by the Commissioner of Education to enter Level II.

(b) Following the meeting with the school district representatives, the county superintendent of schools, in consultation with the assistant commissioner, Division of County and Regional Services, shall recommend to the Commissioner that the district be granted certification with conditions or be directed to Level II.

(c) When a district is certified with conditions the following steps shall be taken:

1. Within 30 days of the county superintendent's recommendation, the district shall be formally notified by the Commissioner of Education that the district is certified with conditions and that the deficiency(ies) must be corrected within the specified period of time.

2. The district shall proceed with the correction of monitoring deficiencies according to established timelines.

3. At the conclusion of the approved timeline for correction of deficiencies, the county superintendent of schools, in consultation with the assistant commissioner, Division of County and Regional Services shall determine the validation necessary to document the district's current status with regard to previously approved indicators.

4. The county superintendent of schools shall verify the district's correction of deficiencies and its current status with regard to previously approved indicators; and shall, in consultation with the assistant commissioner, Division of County and Regional Services, recommend to the Commissioner of Education that the district be:

i. Recommended to the State Board of Education for certification;

ii. Granted an extended amount of time to correct deficiencies when reasonable progress has been demonstrated by the district in correcting its deficiencies; or

iii. Directed by the Commissioner of Education to enter Level II monitoring pursuant to law.

(1) The board of education of a school district which is directed to enter Level II monitoring may appeal that decision to the State Board of Education pursuant to P.L. 1991, c.3.

(d) When a district becomes a Level II District the following steps shall be taken:

1. A district which is directed by the Commissioner of Education to enter Level II monitoring shall be examined by an external review team appointed by the county superintendent of schools. The review team shall consist of members qualified by training and experience to examine specific conditions within the district. The entire cost of the activities associated with the review team shall be paid by the Department of Education.

2. The Commissioner of Education shall direct the county superintendent to establish an open public meeting within the district that is duly advertised and posted whereby parents, school employees and community residents may meet with the county superintendent and external review team to discuss their concerns regarding the district.

3. In conjunction with the Department of Education, and at the direction of the Commissioner, the external review team shall determine which aspects of the district's operation to examine. The examination may be limited to identified deficiencies within the

district or may include all aspects of the district's operations such as educational programs, school district management, school district governance and school district finance.

4. The external review team shall, in addition, examine conditions in the community which may adversely affect the ability of pupils to learn.

5. Within 30 calendar days after its review, the external team shall submit a report to the Commissioner of Education. The report shall include:

i. Findings, conclusions and directives to be used by the district in the development and implementation of a corrective action plan to achieve certification; and

ii. Recommendations as to the technical assistance the district will require to effectively implement the corrective action plan.

6. In addition, the external team may recommend measures to be taken to mitigate adverse community conditions which affect the ability of pupils to learn.

7. The Commissioner of Education shall transmit, within 15 calendar days, the findings of the external review team and shall direct the district to develop a corrective action plan to implement the recommendations.

8. The district, within 30 days of formal notification, shall discuss the findings of the external team at a regular or special meeting of the board of education.

9. Within 60 calendar days of receipt of the directives, the chief school administrator shall submit a corrective action plan approved by the district board of education to the Commissioner for approval.

10. In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district's current expense budget.

11. The Commissioner, where appropriate, shall reallocate funds within the district's budget to support the corrective action plan. Any line item transfers of reallocated funds shall have prior approval of the Commissioner.

12. In cases where the Commissioner determines that additional revenue is needed to implement the corrective action plan, the Commissioner shall recertify a budget for the district.

13. The district shall implement the corrective action plan activities within one year of the Commissioner's formal notification that the plan has been approved. The Commissioner shall ensure that technical assistance is provided to the district to implement the corrective action plan.

i. Monthly, until the district is certified, the county superintendent of schools shall monitor and assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the assistant commissioner, Division of County and Regional Services.

ii. The county superintendent of schools, upon completion of the district's corrective action plan activities, shall determine whether the standards for certification have been achieved and shall submit a formal report to the assistant commissioner, Division of County and Regional Services.

iii. The assistant commissioner, Division of County and Regional Services, shall submit to the Commissioner of Education a formal report which recommends that the district be:

(1) Recommended to the State Board of Education for certification;

(2) Granted an extended amount of time to correct deficiencies when reasonable progress has been demonstrated by the district in correcting its deficiencies; or

(3) Directed by the Commissioner of Education to enter Level III Monitoring pursuant to law;

(A) The board of education of a school district which is directed to enter Level III monitoring may appeal that decision to the State Board of Education pursuant to P.L. 1991 c.3.

6:8-5.2 Determination of Level III districts

(a) A district which fails to correct the deficiencies noted in the Level II evaluation process will be directed by the Commissioner to enter Level III monitoring.

(b) When a district which has had a comprehensive examination of all aspects of its operations by an external review team is directed to enter Level III monitoring, the Commissioner shall prepare an administrative order directing the corrective actions which shall be taken by the district.

1. The corrective actions will be based on the findings and conclusions of the external review team and the monitoring of the Level II plan by the county superintendent.

2. The Commissioner shall insure that technical assistance is provided to the district to implement the corrective actions.

3. If the Commissioner determines, based on the findings of the Level II or Level III review team and the Department of Education, that conditions within the district may preclude the successful implementation of a corrective action plan, he shall direct that a comprehensive compliance investigation be conducted by the State Department of Education and may order any necessary action to insure the security of the books, papers, vouchers and records of the district.

4. In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district's current expense budget.

5. The Commissioner, where appropriate, shall reallocate funds within the district, or take whatever other measures deemed necessary and appropriate to insure implementation of the corrective action. Any line item transfers of reallocated funds shall have prior approval by the Commissioner.

6. In cases where the Commissioner determines that additional revenue is needed to implement the corrective action plan, the Commissioner shall recertify a budget for the district.

7. The district shall implement the corrective action plan within one year of the Commissioner's formal issuance of the administrative order.

i. Monthly, until the district is certified, the county superintendent shall monitor and assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the assistant commissioner, Division of County and Regional Services.

ii. The county superintendent, upon completion of the district's corrective action plan, shall determine whether the standards for certification have been met and shall submit a formal report to the assistant Commissioner, Division of County and Regional Services.

iii. The assistant commissioner, Division of County and Regional Services shall submit to the Commissioner a formal report which recommends that the district be:

(1) Recommended to the State Board of Education for certification; or

(2) Directed by the Commissioner to have a comprehensive compliance investigation conducted by the State Department of Education.

*[(b)]***(c)* When a district which has not had a comprehensive examination of all aspects of the district's operations by an external review team is directed to enter Level III, the Commissioner shall designate the county superintendent to appoint an external review team, whose members shall be qualified by training and experience to examine the conditions in the district.

1. Within three months, in conjunction with the Department of Education, the team shall examine all aspects of the district's operation, including, but not limited to, education, governance, management and finance.

2. Within 30 calendar days after its review, the external team shall report its findings and conclusions, including directives to be utilized in the preparation of a corrective action plan to achieve certification, to the Commissioner.

3. If the Commissioner determines, based on the findings of the Level II or Level III review team and the Department of Education, that conditions within the district may preclude the successful implementation of a correction action plan, he or she shall direct that a comprehensive compliance investigation be conducted by the Department of Education and may order any necessary action to insure the security of the books, papers, vouchers and records of the district.

4. Within 30 calendar days of the receipt of the report, the Commissioner shall prepare an administrative order directing the corrective actions which shall be taken by the district based upon the findings and conclusions of the Level III external review team and the county superintendent's monitoring of the Level II plan.

5. The Commissioner shall insure that technical assistance is provided to the district in order to implement the corrective actions.

6. In reviewing the district's corrective action plan, the Commissioner shall determine the cost of implementing the plan and shall identify those aspects of the plan which are already contained in the district's current expense budget.

7. The Commissioner, where appropriate, shall reallocate funds within the district's budget or take whatever other measures deemed necessary and appropriate to support the district's corrective action plan. Any line item transfers of reallocated funds shall have prior approval by the Commissioner.

8. In cases where the Commissioner determines that additional revenue is needed to implement the corrective action plan, the Commissioner shall recertify a budget for the district.

9. The district shall implement the corrective action plan within one year of the Commissioner's formal issuance of the administrative order.

i. Monthly, until the district is certified, the county superintendent shall monitor and assess the progress of the district in implementing the corrective action plan and shall submit quarterly reports to the assistant commissioner, Division of County and Regional Services.

ii. The county superintendent, upon completion of the district's corrective action plan, shall determine whether the standards for certification have been achieved and shall submit a formal report to the assistant commissioner, Division of County and Regional Services.

iii. The assistant commissioner, Division of County and Regional Services, shall submit to the Commissioner a formal report which recommends that the district be:

(1) Recommended to the State Board of Education for certification; or

(2) Directed by the Commissioner to have a comprehensive compliance investigation conducted by the State Department of Education.

6:8-5.3 Compliance investigation

(a) A comprehensive compliance investigation will be conducted under the supervision of the assistant commissioner, Division of County and Regional Services, under one of the following circumstances:

1. (No change.)

2. After completion of the corrective action plan activities, a district fails to achieve certification and does not demonstrate reasonable progress toward meeting certification standards, pursuant to N.J.A.C. 6:8-5.2(b)9.

(b)-(e) (No change.)

6:8-5.4 Corrective action by Commissioner of Education

Any noncertified district which does not demonstrate reasonable progress toward compliance with the provisions of N.J.S.A. 18A:7A-1 et seq. (Public School Education Act of 1975) and New Jersey Administrative Code Title 6, Education and toward the resolution of major problems shall be submitted to further intervention by the Commissioner of Education, as provided by law.

SUBCHAPTER 6. PREVENTIVE AND REMEDIAL PROGRAMS IN READING, WRITING AND MATHEMATICS

6:8-6.1 Assessment procedures

Each pupil shall be assessed, upon entrance into the educational system and annually thereafter, to identify pupils not meeting State minimum levels of proficiency in reading, writing, and mathematics. These assessment procedures shall be completed no later than one month after the date of enrollment in a district. Pupils so identified shall be provided with an individual comprehensive assessment. In instances of pupil transfers, assessment records shall be forwarded within 10 days in accordance with N.J.A.C. 6:3-2.5(c)9iii.

6:8-6.2 Required supplemental preventive and remedial programs

(a) For each pupil in grades K through 2 who does not meet locally established minimum levels of proficiency in reading, writing, and mathematics and who has not been exempted from these requirements in an individualized education program, the district board of education shall provide a supplemental preventive and remedial program.

(b) For each pupil in grades 3 through 12 who does not meet state minimum levels of proficiency in reading, writing, and/or mathematics and who has not been exempted from these requirements in an individualized education program, the district board of education shall provide a supplemental preventive and remedial program.

(c) The preventive and remedial programs required in (a) and (b) above and the budget plan required in (f) below shall be reviewed and approved by the State Board of Education through the Commissioner or his or her designee. These programs shall be supplemental to the regular program and designed to assist students who have academic, social, economic, or environmental needs that prevent them from succeeding in regular school programs.

(d) To meet the supplemental requirement, district boards of education may provide remediation services in reading, writing, and mathematics, or related services. These may be programs offered during the normal school day or programs offered beyond the normal school day or during summer vacation through the use of an instructional method or in an instructional setting they deem appropriate. District boards of education may provide remedial services through a variety of program models (for example, in-class, pull-out, reduced class size, replacement projects or laboratories).

(e) For each pupil performing below State minimum levels of proficiency after completion of three academic years of instruction beyond kindergarten, the district board of education shall ensure the development and implementation of an Individual Student Improvement Plan. The district board of education shall ensure that:

1. A certified staff member is identified as responsible for developing and implementing the plan and monitoring the progress of the student;

2. The pupil and the pupil's parent(s) or guardian(s) are informed of the need for and content of the Individual Student Improvement Plan in the language or mode of communication which is understood by the pupil and the parent(s) or guardian(s) in accordance with N.J.A.C. 6:3-2.2(k); and

3. Ongoing communication shall take place among those responsible for providing services described in the Individual Student Improvement Plan, the regular classroom teacher, and the parent(s) or guardian(s) of the pupil for whom the plan has been developed.

(f) The district board of education shall submit a budget plan for the preventive and remedial programs contained in (a) and (b) above to the county superintendent for approval as part of the supporting documentation for the annual school district budget. This budget plan shall include a description of the services to be provided including the estimated number of students, the average instructional time and the instructional setting to be used.

(g) The district board of education shall annually evaluate the effectiveness of the preventive and remedial basic skills services, including measuring pupil gains in basic skills proficiency, to ensure that students are meeting State minimum levels of pupil proficiency in reading, writing and mathematics.

6:8-6.3 (Reserved)

6:8-7.1 Promotion, remediation, and graduation procedures

(a) District boards of education shall adopt policies and procedures for:

1.-3. (No change.)

4. The exemption of handicapped pupils from the high school graduation requirements, pursuant to N.J.A.C. 6:28-3.6 and 4.4, 6:39-1.3(e), and (b)6 below.

5.-10. (No change.)

(b) District boards of education shall adopt policies and procedures for high school graduation of all pupils, pursuant to law and rule, which shall include, but not be limited to, performing at

or above the State minimum levels of pupil proficiency on the State-mandated High School Proficiency Test in reading, writing, and mathematics skills.

1. Pupils in grades 9 and 10 who perform below State minimum levels of pupil proficiency on one or more areas of the State-mandated Early Warning Test and pupils in grades 11 and 12 who perform below State minimum levels of pupil proficiency on one or more areas of the State-mandated High School Proficiency Test shall be provided with an individual comprehensive assessment, as specified in N.J.A.C. 6:8-6.1. Based on the individual comprehensive assessment, the pupil shall receive the necessary services to remedy the identified deficiencies. Such services shall include, but not be limited to, the development and implementation of an Individual Student Improvement Plan. This individual plan may be carried out through the regular program or through an extended school day, extended school week, or extended school year. Comprehensive pupil assessment and re-evaluation of the individual plans shall take place at least once each year until all identified deficiencies have been remediated.

2. (No change.)

3. Pupils who perform below State levels of pupil proficiency on one or more areas of the State-mandated Early Warning Test or the High School Proficiency Test shall be provided an opportunity to demonstrate mastery in each academic year.

4.-6. (No change.)

7. All pupils of limited English proficiency must satisfy requirements for high school graduation in accordance with the provisions of this section except:

i. Pupils of limited English proficiency who enter New Jersey schools in grade nine or later may demonstrate that they have attained State minimum levels of proficiency through the Special Review Assessment in their native language, and

ii. Pupils of limited English proficiency who enter New Jersey schools in grade nine or later and who demonstrate that they have attained State minimum levels of proficiency through the Special Review Assessment in their native language must take the Maculaitis Assessment Program and attain the passing level of fluency of 133 raw score points to be eligible for a State-endorsed high school diploma.

8. Any out-of-school youth or adult age 18 or older who has otherwise met all State and local graduation requirements, but has failed to pass the State-mandated High School Proficiency Test may return at times which have been scheduled and publicly announced by the district for the purpose of taking the necessary test. Upon certification of passing the test, a State-endorsed diploma will be granted by the high school of record.

(c) Minimum high school graduation requirements include the following:

1. (No change.)

2. Pupil proficiencies in (c)1 above shall be developed as follows:

i.-ii. (No change.)

iii. For each of those courses mandated by the State Board of Education, *[local school districts]* ***disrict boards of education*** shall establish course proficiences, including but not limited to, the Statewide core proficiencies in the following curriculum areas:

(1)-(8) (No change.)

iv.-v. (No change.)

(d) Subject to approval of the State Board of Education:

1. Each district board of education shall establish graduation requirements on the basis of either course credits, program completion, or a combination of course credits and program completion.

i. Course credit requirements shall be established as follows:

(1)-(3) (No change.)

(4) Credit toward graduation shall be awarded by the following method:

(A) (No change.)

(B) Credit may be assigned by each district board of education for curricular activities.

(C) No change.)

ii. (No change.)

2. (No change.)

(e)-(f) (No change.)

Full text of Subchapter 8, Interim Rules For The Evaluation of Elements and Standards For School Districts Monitored Between January 1, 1984 and December 31, 1986, proposed for repeal may be found in the New Jersey Administrative Code at N.J.A.C. 6:8-8.

Recodify Subchapter 9 Approved Public Elementary and Secondary School Summer Sessions, as Subchapter 8. (No change in text.)

HUMAN SERVICES

(a)

THE COMMISSIONER

County Human Services Advisory Councils and State Human Services Advisory Council

Readoption with Amendments: N.J.A.C. 10:2

Proposed: November 4, 1991 at 23 N.J.R. 3259(a).
Adopted: December 11, 1991 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: December 11, 1991 as R.1992 d.28, **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. 30:1-12.
Effective Date: December 11, 1991, Readoption;
January 6, 1992, Amendments.
Expiration Date: December 11, 1996.

Summary of Public Comments and Agency Responses:

The proposed readoption with amendments was published on November 4, 1991. During the comment period, which closed on December 4, 1991, nine comments were submitted to the agency on the section of the rule pertaining to the County Human Services Advisory Councils (CHSACs). The comments were received from the following entities (in alphabetical order by county):

Joseph E. Gaynor, Chairperson, Atlantic CHSAC
Richard Preissler, Deputy Director, Bergen County Board of Social Services
C. Ruth Ruth, Chairperson, Bergen CHSAC
Ruth B. Boer, Member, Bergen CHSAC
Mary Petti, Chairperson, Morris CHSAC
Peter Lund, Chairperson, By-Laws Committee, Passaic CHSAC
Kathleen Wood, Coordinator, Sussex CHSAC
Judi Prasser, Chairperson, Union CHSAC
Ruth Ballou, Chairperson, Warren CHSAC

No comments were received on the section of the rule pertaining to the State Human Services Advisory Council.

Comments and suggestions were made on the Purpose and scope, Definitions, Membership requirements, Required subcommittees, and Procedural requirements sections of the rule. It should be noted that one entity, the Warren CHSAC, approved the rule as proposed.

COMMENT: In regard to N.J.A.C. 10:2-1.1, Purpose and scope, several comments stated that the additional responsibility of participating in the Department's Open Budget Review Process should be made optional unless additional funds are included in its contracts with the CHSACs for this purpose.

RESPONSE: The Department disagrees. The participation of the CHSACs in the Open Budget Review Process is essential. The Department points out that, when additional responsibilities are required of the CHSACs, the Department has reprioritized and/or redefined their other responsibilities to accommodate the new. No change was made in the rule in this regard.

COMMENT: In regard to the definitions section, N.J.A.C. 10:2-1.2, one comment recommended a change in the definition of "Contracting policy." The comment pointed out that the Department does not actually contract directly with the CHSACs.

RESPONSE: The Department agrees. It actually contracts with either the Chief Executive Officer of County Government, where applicable, the Board of Chosen Freeholders, where applicable or the Board of Directors of an organization designated as a CHSAC. The Department indeed does not, in most cases, contract directly with the CHSAC. A change has been made to the text to reflect this point.

COMMENT: Also in regard to the definitions section, one comment recommended that the definition of "family member" be amended to include the child of a person who is, or has been, a recipient of public or private human services.

RESPONSE: The Department agrees and a change has been made in the text to reflect this point. The Department intended the definition to include immediate family members, and the addition of "child" completes this definitional intent.

COMMENT: A number of comments expressed concern about the definition of "provider representative." Their concern centered on the inclusion of agency board members and volunteers in this definition and the inter-relationship of this definition with that of "consumer." They were concerned that a consumer advocate appointed into the consumer category of membership would also have to be considered a provider representative if he or she also served as an agency board member. They were also concerned that a volunteer appointed to the consumer category of membership would also have to be considered as a provider representative. The comments expressed concern that this would frustrate the CHSAC's attempts to conform to the 49 percent limit on provider representatives on the Council membership.

RESPONSE: The Department agrees that this will complicate CHSAC's task in identifying members who cannot be considered provider representatives, according to the definition included in the rule. However, the Department does not agree to change the text in this regard. It is of paramount interest to the Department that "provider representatives," as defined in the rule, be identified as such on CHSAC membership.

COMMENT: In regard to N.J.A.C. 10:2-1.7, Procedural requirements, one comment expressed concern that the language at N.J.A.C. 10:2-1.7(b), which established a January 1 to December 31 evaluation period, would conflict with and complicate current practice of the County Human Services Advisory Councils (CHSACs). The comment stated that very few CHSACs operate on a calendar year basis. This would be particularly burdensome in regard to membership.

RESPONSE: The Department agrees that the County Human Services Advisory Councils may renew their membership rosters to conform to the new rule in accordance with past practice, but that their memberships must be in compliance with the new rule no later than January 1, 1993. A change has been made to the text to reflect this point.

COMMENT: In regard to N.J.A.C. 10:2-1.3, Membership requirements, two comments stated that the new membership requirements would necessitate an overall increase in the size of the CHSACs.

RESPONSE: The Department points out that the rule does not place a limit on the size of the CHSACs. The Department supports the CHSACs having flexibility in this area.

COMMENT: In regard to membership, one comment recommended that the language mandating the inclusion of new members be amended to make the inclusion of these representatives optional.

RESPONSE: The Department disagrees. The Department believes that requiring representation from these sectors (namely the local public housing agency, the CIACCs, and the CARTs) will assure their inclusion. The Department has initiatives planned and/or being implemented that involve these sectors and, therefore, their representation on the CHSAC is essential. No change is made to the rule in this regard.

COMMENT: Also in regard to membership requirements, one comment recommended that only one of the representatives from the juvenile justice (youth concerns) area be a voting member of the CHSAC.

RESPONSE: The Department disagrees. Each of the required members from the youth concerns sector has a unique perspective that warrants each having a vote.

COMMENT: Two comments recommended that the limit on the percentage of the membership who could be "provider representatives" be increased, in order to accommodate the new members required by the rule who would, very likely, be considered as provider representatives.

RESPONSE: The Department disagrees. The new members required by the rule will have to be included within the 49 percent limit on provider representation. The Department feels it is essential to place this limit on provider representation on the CHSACs in order to maintain their credibility as entities that make funding decisions at the county level.

COMMENT: In regard to N.J.A.C. 10:2-1.5, Required subcommittees, one comment suggested that the CEAS Subcommittee "stand separate from the CHSAC."

RESPONSE: The Department disagrees. It is essential that resource allocation plans developed by the CEAS Committee be approved by the CHSAC to ensure their concurrence. It is also essential that the County Comprehensive Homeless Assistance Strategy be coordinated with the County Human Services Plan. The Department believes that these two goals are best accomplished by having the CEAS Committee operate under the auspices of the CHSAC.

COMMENT: One comment stated that the change in voting status of the DEA and DCA representatives may result in their reduced participation.

RESPONSE: The Department will ensure active participation by the DEA representative, regardless of voting status and will work with DCA to ensure the same. The Department believes that State department representatives having a vote on issues relating to local decision making is inappropriate.

COMMENT: Several comments stated concern about the change in CEAS Subcommittee membership that would include both the County Welfare Agency (CWA) Director and an additional designee of the CWA Director's choice (a person with expertise in the issue of homelessness). One comment suggested that this is incongruous with the membership of the CHSAC as a whole, where the CWA Director or his or her designee is required to be a member. Two comments suggested that, if the CWA was to have an additional member, then that member should act as a non-voting member.

RESPONSE: The Department disagrees and feels strongly that the CWA Director is an essential member of this Committee. Further, the Department asserts that an additional member with particular expertise in homelessness is essential as well. Also, the Department believes it is essential that both be voting members of the Committee because of the CWA's responsibilities in this area. The CWA Director has the option of sitting on the CHSAC or appointing a designee.

COMMENT: One comment questioned the language referring to "emergency services" in N.J.A.C. 10:2-1.5(a) and how this term relates to the term "core services" currently being used by the CHSACs.

RESPONSE: The Department agrees that this term should be more specific in this regard, that designated core services are included within the term emergency services, and such language is included in the text.

COMMENT: One comment expressed concern that the commenter's county did not have a designated community development block grant representative or a public housing agency representative and that this would affect their ability to meet the required membership standards.

RESPONSE: The Department points out that there are provisions in the rule for the CHSACs to request waivers to the membership requirements that would cover instances such as this as well. No change has been made in the rule in this regard.

COMMENT: One comment pointed out that the "required subcommittees" section of the rule was mis-numbered/lettered in the proposal. In addition, another comment indicated that the reader took the section to mean that the CEAS and REACH (JOBS) Committees were somehow being merged and opposed this change.

RESPONSE: The Department has included technical corrections in this regard. The two Committees are not being merged.

COMMENT: One comment noted that the reference to the County Comprehensive Homeless Assistance Strategy was inaccurate in the proposed rule. It was referred to as the County Comprehensive Homeless Assistance Plan. In addition, the acronym used was C-CHSAC rather than C-CHAS, a typographical error.

RESPONSE: The Department has included technical corrections in this regard.

COMMENT: In regard to the JOBS Subcommittees, two comments stated that any required subcommittees should be accompanied by additional Department funding to staff support and administration.

RESPONSE: The Department points out that this is not a new requirement. The CHSACs have been required since 1988, with the advent of the REACH Program, to maintain a REACH Subcommittee as delineated in the Public Assistance Manual. The JOBS Oversight and Monitoring Committee simply renames the REACH Subcommittee and its inclusion in the rule is intended to make the rule as inclusive of the CHSACs responsibilities as possible.

COMMENT: One comment stated that the role and function of the JOBS subcommittee should be clarified and expanded.

RESPONSE: The Department acknowledges that the language contained in the rule does little in this regard. The Division of Economic Assistance will provide this information through the Public Assistance Manual.

COMMENT: One comment stated that the rule should clarify that the Subcommittee pertains to the REACH/JOBS program.

RESPONSE: The Department acknowledges that there may be some confusion at first in this regard. However, the REACH program is now know as the JOBS Program.

In regard to N.J.A.C. 10:2-1.7, Procedural requirements, all of the comments received concerned the conflict of interest policy. Generally, the comments were concerned that the policy was more strict than those currently in use by the CHSACs.

COMMENT: One comment recommended that the CHSACs be allowed to "seek participation by members in conflict only to the extent that they may be able to answer technical questions, provided that equal access for all affected parties to comment is assured."

RESPONSE: No change has been made in the language of the rule in this regard. The Department representative will monitor CHSAC compliance with the conflict of interest policy, and determine, as required, application of that policy.

COMMENT: One comment suggested that the CHSACs be permitted to determine their conflict of interest policies by making them "consistent with state law."

RESPONSE: The Department believes it necessary to be more specific than this in regard to the conflict of interest policy applicable to CHSACs. The intent is to assure that the CHSACs' credibility is not compromised, especially in regard to their responsibilities to make funding allocation recommendations.

COMMENT: One comment recommended that the language pertaining to the need for members to review the potential for conflict and, as needed, provide full disclosure on their "child, parent, grandparent, ... and any other member of the immediate household" be deleted from the rule.

RESPONSE: The Department believes that family members and members of the immediate household present the possibility of conflict of interest and, therefore, information pertaining to their affiliations is relevant in deciding whether or not a CHSAC member is in conflict on a particular issue. No change has been made to the rule in this regard.

COMMENT: One comment stated that the enforcement of the provisions in the rule regarding conflict of interest could result in the CHSACs not having a quorum to conduct business.

RESPONSE: The Department believes that this provision does not affect the CHSAC quorum. CHSACs can specify in their By-Laws that the necessary majority in voting can exclude those excluded on the issue by conflict of interest.

Summary of Agency-Initiated Changes

1. At N.J.A.C. 10:2-1.3(a)10, the paragraph heading is being changed from "Juvenile Justice Representation" to "Representation of Youth Concerns." The Department has initiated this change because the sectors included in this category of membership represent the broader interests of youth, rather than strictly juvenile justice.

2. For all references at N.J.A.C. 10:2-1.5(a) pertaining to the "required subcommittees," the Department is changing the word subcommittee to committee. This is appropriate since the CHSACs are themselves councils and not committees.

3. At N.J.A.C. 10:2-1.7(b), the phrase specifying an annual contract review period has been deleted. This will allow the Department to adjust its annual review period through the contract.

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

SUBCHAPTER 1. COUNTY HUMAN SERVICES ADVISORY COUNCILS

10:2-1.1 Purpose and scope

(a) (No change.)

(b) County Human Services Advisory Councils' activities include, but are not limited to:

1. Facilitation and coordination of the Department of Human Services' annual public budget review process in each county;

2. Review and comment on human services proposals;

3. Preparation of allocation plans including those required for the Social Services Block Grant (including fair funding formula funds), State appropriations for the homeless, Peer Grouping, and other funding streams as required by the Department of Human Services;

4. Review of existing purchase-of-service contracts;

5. Coordination and consolidation of the local human services delivery systems;

6. Development and implementation of a county human services plan to meet local needs; and

7. Designation of appropriate representation for participation on the State Human Services Advisory Council.

(c) County Human Services Advisory Councils shall be comprised of provider representatives, consumers of human services, and other concerned individuals and shall be generally reflective of the demographic characteristics of their respective county populations.

10:2-1.2 Definitions

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

"Certification process" means the annual review and approval of the CHSAC conducted by a representative of the Department of Human Services.

"Consumer" means a person who is, or has been, a recipient of public or private human services; or, a consumer advocate (that is, a volunteer or member of an advocacy group).

"Contracting process" means the action by which the New Jersey Department of Human Services enters into a written agreement with the *[Human Services Advisory Councils]* ***Chief Executive Officer of County Government, where applicable, the Board of Chosen Freeholders, where applicable, or the Board of Directors of an organization designed as a CHSAC*** to perform specific levels of service, planning objectives, and to receive funding as set forth by the Department.

"Department" means the New Jersey Department of Human Services.

"Family member" means a spouse, ***child,*** parent, guardian, or a sibling of a person who is, or has been, a recipient of public or private human services.

"Minority interest representatives" means members of major underserved groups such as the aged (over 60), females, blacks, or Hispanics.

"Provider representative" means an employee, board member, or other volunteer of an entity which is eligible to hold a contract(s) with the Department of Human Services.

"Target populations" means those populations currently under the purview of the New Jersey Department of Human Services, such as children and families in need of services, persons needing mental health services, persons with developmental disabilities, low income persons and public assistance recipients, blind and visually impaired persons, persons who are deaf or hard of hearing, the disabled elderly, homeless individuals and families, other disabled persons, and under-served populations requiring services from the Department.

10:2-1.3 Membership requirements

(a) County Human Services Advisory Councils shall contain the following membership for certification by the Department:

1. Public and Private Provider Representation: Councils shall be comprised of both public and private human services provider representatives. Provider representative membership shall not exceed 49 percent of the total membership. Provider representative membership shall represent as many target populations and service areas encompassed by the Department as possible. Representation shall include:

i. County freeholder or county executive, or a designee;

ii. The county welfare agency director or designee;

iii. The county Division of Youth and Family Services District Office Manager, or another Division of Youth and Family Services' designee.

2. Staff of the Department of Human Services, as designated by the Commissioner, as an ex-officio, non-voting member.

3. Consumer and Family Member Representation: Consumer and family member representation shall be at least 25 percent of the total membership. Current or former recipients of service shall constitute one-half of consumer and family member membership.

Consumers and family members shall represent a cross-section of the human services community and target populations, as defined above.

4. Demographic Representation: The CHSAC shall reflect the county's demographic make-up in terms of age, ethnicity and sex, according to the latest census data. Minority interests must be at least proportionate to the minority composition of the county.

5. Target Population Representation: To the fullest extent possible, County Human Services Advisory Councils shall be representative of target populations and service areas.

6. Other representation shall include a local public housing agency representative and may include the areas of employment, aging (area agency on aging), health (county and local health offices) substance abuse, education, community action, legal aid and vocational rehabilitation.

7. State representatives, as indicated by the meeting agenda, from the Department's Divisions. Participation by these departmental employees shall be in an ex-officio, non-voting capacity. The representative of the Department shall be responsible for ensuring coordination and participation from these Divisions when necessary.

8. Voluntary sector representation: May include private planning councils and major donors or funders of local human services (for example, United Ways).

9. Major geographic sub-divisions (for example, cities) should be encouraged to participate in County Human Services Advisory Councils.

10. *[Juvenile Justice Representation]* ***Representation of Youth Concerns:*** Representatives of boards and commissions which represent the needs of at-risk children and youth (such as the County Youth Services Commissions, the County Inter-Agency Coordinating Councils (CIACCs), and the Case Assessment Resource Teams (CARTs)) shall be included as voting members.

11. Membership from other county-level advisory boards and commissions may be included as voting members.

12. Other representation should include those representatives who the county believes would provide a valuable contribution to human services planning (for example, labor unions, private businesses, foundations).

10:2-1.4 Relationship to other county advisory groups

In its relations to other county advisory groups, the County Human Services Advisory Council shall be the principal human services advisory body and, as such, should maintain a liaison with other related planning and/or advisory groups in the county. Other human services related planning or advisory groups may function as subcommittees, with a member of the existing group sitting on the County Human Services Advisory Council.

10:2-1.5 Required *[subcommittees]* ***committees***

(a) Each County Human Services Advisory Council shall establish a Comprehensive Emergency Assistance System (CEAS) *[Subcommittee]* ***Committee*** as a standing *[subcommittee]* ***committee***. This standing *[subcommittee]* ***committee***, which shall serve as the primary vehicle for insuring the delivery of emergency services ***(including designated core services)*** within a county, shall:

1. Maintain and annually update the component part of the county human services plan and other planning documents regarding services for homeless individuals and families as required by the Department such as the County Comprehensive Homeless Assistance *[Plan]* ***Strategy*** or *[C-CHSAC]* ***C-CHAS*** (which is required to assist the Department to meet the Federal requirements of P.L. 101-625, 104 STAT 4079, codified at 24 C.F.R. 91.02);

2. Recommend resource allocation plans for funds brought before the *[subcommittee]* ***committee*** for services to homeless families and individuals;

i. The full County Human Services Advisory Council shall give final approval; *[and]*

3. Maintain a core membership standard and include, at a minimum, but not limited to, the following voting members:

i. The County Welfare Agency Director;

ii. One additional designee of the County Welfare Agency Director's choice with expertise in homelessness;

iii. A representative of the District Office of the Division of Youth and Family Services;

iv. A local community development block grant representative;

v. A local public housing agency representative;

vi. A provider representative of the homeless mentally ill, and

vii. Representatives from the municipal welfare sector, public and private non-profit provider agencies serving the homeless population, consumers of emergency food and shelter services and/or a representative of a consumer advocacy organization*[.]***;***

[(b) Non-voting subcommittee membership shall include:]

4. Include as non-voting committee members:

*[1.]***i.*** A Department of Human Services representative;

*[2.]***ii.*** A Department of Community Affairs representative;

*[3.]***iii.*** A Division of Mental Health and Hospitals representative; and

*[4.]***iv.*** A Division of Economic Assistance representative*[.]***;***

5. Strongly encourage other *[(c) Other]* State Department representatives (including Education, Health, and Labor), and private planning councils (such as United Ways) *[should be strongly encouraged]* to coordinate related services through participation on the CEAS *[subcommittee.]* ***Committee; and***

[(d) The] ***6. Select the*** CEAS *[subcommittee]* ***Committee*** chairperson *[shall be selected]* in accordance with the process established by each respective County Human Services Advisory Council.

*[(e)]***(b)*** Each County Human Services Advisory Council shall establish and maintain a JOBS Oversight and Monitoring *[Subcommittee]* ***Committee*** as a standing *[subcommittee]* ***committee*** in accordance with guidelines established in the Public Assistance Manual at N.J.A.C. 10:81-14.23.

10:2-1.6 Membership waiver requests

Membership requirements may be waived by the Department. Waiver requests shall be presented in writing from the County Human Services Advisory Council to a Department representative. Waiver requests which violate the policy goal of protection of the interests of at risk, disabled and minority populations shall not be approved. Waivers would apply for a term of one year or until the County HSAC's certification has expired.

10:2-1.7 Procedural requirements

(a) County Human Services Advisory Councils shall:

1. Maintain a clearly identified structure and operational procedures specified in by-laws;

2. Maintain an allocation process, which at a minimum, includes a request for proposals process (in accordance with N.J.A.C. 10:3-3), a proposal review process, an appeals process, and a conflict of interest policy;

i. The appeals process should, at a minimum, be sent to each applicant agency responding to a CHSAC's Request for Proposal for Department of Human Services funding. The appeals committee should consist of membership that is separate from those who actively participated in the agency review and allocation process.

ii. The conflict of interest policy should, at a minimum, preclude CHSAC members from participating in their official capacity in discussions and/or decision making regarding funding or monitoring of programs for which they are employed, serve as a board member or as a volunteer, or have a financial interest. In addition, the members should review the potential for conflict on an annual basis and, as needed, provide full disclosure including information relating to themselves, their spouse, other immediate family members (including child, parent, grandparent, grandchild, uncle, aunt, brother, sister, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law, sister-in-law), and any other member of the immediate household (a model Conflict of Interest Policy is available upon request); and

3. Maintain a contract review policy for all renewals of purchase-of-service contracts funded through the Human Services Advisory Council allocation recommendation process, to determine continued compliance with the county human services plan priorities and to assess qualitative aspects of the contracts. Renewal recommenda-

tions shall be submitted to the appropriate contracting Division and, when appropriate, to the County Freeholder Director or County Executive. State law (N.J.S.A. 30:4-24.3) and Department Administrative Order 2:01 concerning confidentiality of client records will determine their accessibility to the County HSAC's for the purposes of contract review.

(b) The functioning of each Council shall be evaluated through annual contract review*[, for the period January 1 to December 31,]* by a Department representative to assess its functioning as it relates to the projects assigned by the Department of Human Services as well as the fulfillment of its level of service under its contract with the Department.

(c) The degree to which the Council meets membership requirements, as required by N.J.A.C. 10:2-1.3, shall be evaluated through the certification process by a Department representative. ***The Council may proceed to elect members in accordance with past practice. However, membership must be in compliance with this chapter no later than January 1, 1993.***

SUBCHAPTER 2. STATE HUMAN SERVICES ADVISORY COUNCIL

10:2-2.1 Purpose and scope

(a) The purpose and scope of the State Human Services Advisory Council is to provide a forum for public leaders to have input into Statewide human services policy and to work toward the achievement of Statewide human services goals.

(b) The State Human Services Advisory Council shall be organized to:

1. Advise the Commissioner of the Department of Human Services with respect to the development and implementation of human services policy;

2. Participate and offer advice on the development of the Department's annual public budget review process;

3. Respond and react to information received from the Department;

4. Communicate and share such information with the County Human Services Advisory Councils and the human services community at large;

5. Share the community response with the Department; and

6. Initiate discussion with the Department on statewide issues, priorities, and specific programs.

10:2-2.2 Membership Requirements

(a) The State Human Services Advisory Council shall be appointed by the Commissioner of the Department of Human Services after consultation with the Chairperson and shall consist of:

1. Twenty-six at-large members who are recognized leaders in human services and who represent a wide and varied cross section of the human services community Statewide;

2. A representative of each of the 21 County Human Services Advisory Councils (CHSACs) officially designated by the respective Council to vote and attend regular meetings. This representative must be a member of the County Human Services Advisory Council (a volunteer);

3. Non-State employees representing and designated by the direct service related Divisions of the Department. These members shall be appointed by the Commissioner in consultation with the Division Director. No more than three representatives from any Division shall be designated, one of which shall be a consumer of that Division's services. The representatives may be members of a Division Advisory Group;

4. County Human Services Directors or County Human Services Advisory Council staffpersons (in counties where there is no Director of Human Services or where the CHSAC is outside of county government), one from each county, as ex officio, non-voting members; and

5. Representatives from various State Departments related to human services, appointed by the Commissioner of the respective Department, including, but not limited to, the Departments of Health, Education, Labor, Corrections, Community Affairs, and the Public Advocate. In addition, liaisons from appropriate councils, committees, and boards may be appointed. No more than one representative from each Department or council, committee, or board shall be designated. Representatives shall be chosen who have responsibilities related to human services. Representatives in this category are ex officio, non-voting members.

(b) The Chairperson of the State Human Services Advisory Council shall be selected by the Commissioner of the Department of Human Services and shall serve, within his or her term as a member of the Council, at the discretion of the Commissioner.

(c) The State Human Services Advisory Council shall reflect a balance among the sectors of the human services community (considering age, ethnicity, sex, direct service providers, and non-providers) and the Department's target populations. In addition, special attention shall be given to including consumers of human services in the membership.

(d) The terms of office shall be as follows:

1. Regarding at-large and Division constituency representatives, members shall serve for three-year terms or until a successor is appointed by the Commissioner. These terms shall commence on January 1st of the respective year.

i. Terms shall be staggered with one-third of the membership eligible for reappointment or replacement each year. Initially, the length of terms will be decided by random selection within categories of membership.

2. Regarding the CHSAC Representatives, if the CHSAC Chairperson is the representative, that person shall serve as a member of the Council for the length of his or her term as Chairperson or until another representative is designated. If a representative other than the Chairperson is designated, that person shall serve until another representative is so designated.

3. Regarding Inter-Departmental Representatives, members shall serve at the discretion of the respective Department's Commissioner and their terms shall commence on the date of appointment.

4. The Commissioner of the Department of Human Services, in consultation with the Chairperson, shall establish staggered memberships for both the At-Large and Division Constituency Representatives.

(e) Attendance requirements are as follows:

1. Members who have not participated in the work of the Council either at two full Council meetings or through a committee within a six-month period shall be contacted by the Chairperson regarding his or her intent to participate.

2. Members who are not active in the work of the Council for a period of one year shall be recommended for removal by the Chairperson to the Commissioner.

(f) Members are expected to actively serve on at least one of the Council's standing committees. Members may participate on the committee of their choice in consultation with the Chairperson, with the exception of the Executive Committee.

10:2-2.3 Administration

(a) The State Human Services Advisory Council shall meet at least quarterly throughout the year.

(b) The State Human Services Advisory Council and its standing committees shall be staffed by employees of the Department. Resources and assistance to the Council will be provided by the Department.

10:2-2.4 Standing Committees

(a) The Chairperson of the State Human Services Advisory Council and the Commissioner of the Department of Human Services shall establish such standing committees and ad hoc committees as are required to carry out the goals of the Council. The Chairperson and the Commissioner shall determine the size, membership, and mandate of each committee.

(b) The State Human Services Advisory Council shall have, at a minimum, the following standing committees:

1. An Executive Committee, composed of the Chairperson and the standing committee Chairpersons, as well as the Chairpersons of any ad hoc committees. The Chairperson may appoint additional members.

i. This committee is responsible for setting the agenda of each full State Human Services Advisory Council meeting. Other

responsibilities include, but are not limited to, reviewing recommendations for membership which are forwarded to the Commissioner of the Department of Human Services, reviewing of all committee reports and recommendations, and providing direction for the overall operation of the State Human Services Advisory Council.

ii. The Executive Committee may also act on behalf of the full Council on urgent matters at the discretion of the Chairperson. Actions taken by the Executive Committee will be reported to the full Council by the Chairperson at Council meetings.

2. A Legislation and Regulations Committee, the responsibilities of which include, but are not limited to:

i. Reviewing and analyzing important human services legislation and regulations; and

ii. Proposing recommendations regarding the need for future human services legislation and regulations.

3. A Policy and Operations Committee, the responsibilities of which include, but are not limited to:

i. Reviewing, on an ongoing basis, the interrelationships of Department of Human Services' Divisions and other State Departments with the intent of channeling any problems, concerns, or ideas for improvement to the Commissioner of the Department of Human Services;

ii. Identifying and communicating problems, issues, or urgent needs relating to the impact of Department policies on local communities and/or clients; and

iii. Investigating issues and concerns of contract providers and making recommendations for improvements.

4. A Finance and Budget Committee, the responsibilities of which include, but are not limited to:

i. Participating in the Department of Human Services' annual public budget review process, reviewing the Department's budget and making recommendations thereon to the Commissioner;

ii. Developing, among its members, an expertise on the composition of the Department's budget, how it is developed, the budget process overall and sharing that expertise with the full Council; and

iii. Reviewing and analyzing important human services funding initiatives.

5. A County Human Services Advisory Council Representatives' Advisory Committee, the responsibilities of which include, but are not limited to:

i. Reviewing the role of the CHSAC representatives as members of the State Human Services Advisory Council and making recommendations to improve their involvement; and

ii. Providing a forum for the CHSAC representatives to bring CHSAC issues and concerns to the attention of the Council and, thereby, the Commissioner of the Department of Human Services.

6. A Minority Issues Advisory Committee, the responsibilities of which include, but are not limited to:

i. Reviewing the Department's programs and services and their delivery in terms of availability, accessibility, quality and sensitivity to minority populations and cultures;

ii. Informing and sensitizing the Department to the human services needs of minorities;

iii. Identifying gaps in service and making recommendations for remediation; and

iv. Participating in the planning and implementation of the Department's programs, services, and policies in regard to minorities.

(c) The advice and recommendations emanating from the operation of the standing committees will be processed through the Executive Committee and through the full Council. Exceptions to this rule are at the discretion of the Chairperson.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

New Jersey Care . . . Special Medicaid Programs Manual

Presumptive Eligibility Process; Administration

Adopted Amendments: N.J.A.C. 10:72-6.1, 6.2, 6.4 and 6.5

Adopted Repeal and New Rule: N.J.A.C. 10:72-6.3

Adopted New Rule: N.J.A.C. 10:72-6.4

Proposed: September 16, 1991 at 23 N.J.R. 2827(a).
Adopted: December 3, 1991, by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: December 5, 1991 as R.1992 d.10, **without change.**

Authority: N.J.S.A. 30:4D-3i, 30:4D-7, 30:4D-7a, b and c; 30:4D-12; Section 1920(a) of the Social Security Act, codified as 42 U.S.C. 1396 r-l.

Effective Date: January 6, 1992.
Expiration Date: August 27, 1992.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

10:72-6.1 Scope

(a) The presumptive eligibility determination makes it possible for a pregnant woman to receive ambulatory prenatal care from a Medicaid participating provider for a temporary period prior to application for Medicaid benefits and while a Medicaid application is being processed by the county welfare agency. Presumptive eligibility continues until the county welfare agency reaches its formal eligibility determination as follows:

1. (No change.)

2. The period of presumptive eligibility will terminate:

i. If the woman has filed an application with the county welfare agency, on or before the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the date a determination of eligibility or ineligibility for Medicaid is made by the county welfare agency; or

ii. If the pregnant woman fails to file an application with the county welfare agency, on the last day of the month subsequent to the month in which she was determined presumptively eligible.

(b) A qualified provider shall be:

1.-3. (No change.)

4. Trained and approved by the Division of Medical Assistance and Health Services for the purposes of making presumptive eligibility determinations.

i. The Division of Medical Assistance and Health Services will monitor the presumptive eligibility determinations made by qualified providers. In the event the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to procedural requirements, appropriate staff of the Division will initiate corrective action. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements will result in the Division revoking approval for that provider to make presumptive eligibility determinations.

10:72-6.2 Responsibilities of a qualified provider

(a) From preliminary information provided by a woman whose pregnancy has been medically verified, the qualified provider shall determine if the pregnant woman meets the eligibility criteria of this chapter as it applies to pregnant women. The qualified provider must obtain sufficient information from the pregnant woman to complete the Certification of Presumptive Eligibility (FD-334) by having the pregnant woman complete, sign and date a referral for Medicaid benefits as designated and provided by the Division of Medical Assistance and Health Services. For purposes of the presumptive eligibility determination, the qualified provider shall request from

the pregnant woman only that information necessary to determine her presumptive eligibility or ineligibility. The qualified provider shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the pregnant woman's statements.

1. For any pregnant woman determined presumptively eligible, the qualified provider shall complete and sign the FD-334. The completed FD-334 together with the pregnant woman's New Jersey Care Pregnant Women and Infants Application Referral (FD-335) for Medicaid shall be mailed or otherwise forwarded to the county welfare agency of the pregnant woman's county of residence within two working days of the presumptive eligibility determination. The qualified provider shall also forward a copy of the pregnant woman's Certification of Presumptive Eligibility (FD-334) to the Division of Medical Assistance and Health Services. The qualified provider shall inform the pregnant woman that her presumptive eligibility provides only limited services for a period of time not to exceed the length of the presumptive eligibility period, and that she must contact the county welfare agency in order to set up an appointment to complete the application process for Medicaid benefits. The qualified provider shall give the presumptively eligible pregnant woman a copy of both the Certification of Presumptive Eligibility (FD-334) and her New Jersey Care Pregnant Women and infants Application Referral (FD-335) for Medicaid benefits. The qualified provider shall advise the presumptively eligible pregnant woman, in writing, of the address and telephone number of the appropriate county welfare agency office.

2. (No change.)

10:72-6.3 Responsibility of the Division of Medical Assistance and Health Services

(a) Upon receipt of a properly completed Certification of Presumptive Eligibility (FD-334) from the qualified provider, Division staff shall:

1. Assign a presumptive eligibility number from a log of unissued numbers:

2. Create an eligibility record on the Medicaid Eligibility Status File;

3. Issue a Medicaid Eligibility Identification (MEI) Card; and

4. Notify the qualified provider and the appropriate county welfare agency of the presumptive eligibility identification number assigned to the recipient.

10:72-6.4 Responsibility of the county welfare agency

(a) Upon receipt of the Certification of Presumptive Eligibility (FD-334) and a properly completed New Jersey Care Pregnant Women and Infants Application Referral (FD-335) from the qualified provider, the county welfare agency shall:

1. Check the Medicaid and Medically Needy Eligibility Status Files for existing Medicaid eligibility.

i. If the recipient is receiving Medicaid benefits as an AFDC child or adult, a Medicaid Special individual, or a New Jersey Care or Medically Needy pregnant woman, no further action shall be required by the county welfare agency.

ii. If the recipient is receiving Medicaid benefits as a Medically Needy child or Medically Needy disabled adult, a separate case shall be established which would entitle the recipient to receive additional prenatal service available to Medically Needy pregnant women. In such instances, the county welfare agency shall schedule a face-to-face interview with the recipient to verify all factors of eligibility before a final determination of eligibility or ineligibility is made.

iii. If the recipient is an AFDC adult or child, and there are indications of a change in circumstances, such as a marriage of the pregnant woman, the county welfare agency may schedule a face-to-face interview with the recipient to verify all factors of continued eligibility as an AFDC case before a final determination of eligibility or ineligibility is made. However, she cannot be found ineligible for Medicaid solely because she does not meet AFDC standards for cash assistance, but must be evaluated for eligibility for other Medicaid programs without regard to any changes which occurred after the determination of presumptive eligibility.

2. Notwithstanding the application disposition standards in N.J.A.C. 10:72-2.1(d), the county welfare agency shall arrive at a case disposition within the presumptive eligibility period.

1. The policy at N.J.A.C. 10:72-2.1(d)2 concerning delayed application processing applies equally to the processing of the application of a presumptively eligible pregnant woman. In the event the processing standard is exceeded, the qualified provider shall be notified that the processing of the woman's Medicaid application has been delayed. The Division of Medical Assistance and Health Services shall also be notified of any such delay, and shall take steps to continue her presumptive eligibility until a final determination is made.

ii. In the event the processing of the application is delayed beyond the presumptive eligibility period, the county welfare agency shall provide the applicant with written notification prior to its expiration setting forth the specific reasons for the delay.

3. In the case of a presumptively eligible pregnant women who is determined ineligible for Medicaid within the presumptive eligibility period, the woman's eligibility shall terminate as of the day of the ineligibility determination.

10:72-6.5 Responsibility of the applicant

A presumptively eligible pregnant woman must contact the county welfare agency during the presumptive eligibility period so that a face-to-face interview can be scheduled. As part of the eligibility determination process for Medicaid, the pregnant woman must be interviewed by county welfare agency staff, complete any forms required as a part of the application process, and assist the county welfare agency in securing evidence that verifies her statements regarding eligibility.

10:72-6.6 Notification and fair hearing rights

(a) For a presumptively eligible pregnant woman who is subsequently determined ineligible for Medicaid benefits:

1-2. (No change.)

(b) For a presumptively eligible pregnant woman whose eligibility for Medicaid has not yet been determined within the presumptive eligibility period:

1. (No change.)

2. In accordance with N.J.A.C. 10:72-2.1(d)3, the county welfare agency shall provide the pregnant woman with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the Medicaid application processing. The pregnant woman is entitled to a fair hearing based on the county welfare agency's failure to determine her Medicaid eligibility or ineligibility within the application processing period.

(c) (No change.)

(a)

DIVISION OF ECONOMIC ASSISTANCE
Aid to Families with Dependent Children Standard of Need
Adopted New Rule: N.J.A.C. 10:82-1.1A

Proposed: February 4, 1991 at 23 N.J.R. 285(a).
Adopted: November 25, 1991 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: November 26, 1991 as R.1992 d.1, **without change.**

Authority: N.J.S.A. 44:10-3.

Effective Date: January 6, 1992.
Operative Date: July 1, 1992.
Expiration Date: August 24, 1994.

Summary of Public Comments and Agency Responses:

Public hearings on the proposed new rule were held on April 19, 1991 in Camden, East Orange and Trenton, New Jersey. An Assistant Director acted as the hearing officer in each of the three sites. No formal recommendations were issued by the hearing officers in regard to the proposal. A copy of the public hearing records may be reviewed or obtained by contacting the Division of Economic Assistance, CN-716, Trenton, New Jersey 08625, or by phone at (609) 588-2289. As a result of these hearings the comment period was extended until May 6, 1991.

After reviewing the comments submitted, the Department is adopting the proposed amendments without change. The following individuals submitted written and/or oral comments:

Richard Preissler, Bergen County Board of Social Services
Beverly J. Bearmore, Ocean County Board of Social Services
Wilfredo Caraballo, Department of the Public Advocate
Jack Martin, Camden County Board of Social Services
Edward Walsh, New Jersey Catholic Conference
Barbara Kutsher, League of Women Voters
Richard H. Bakley, Camden County Board of Social Services
David Sciarra, Office of the Public Advocate
Elaine Meyerson, Shelter Our Sisters
Cecilia Zalkind, Association for Children in New Jersey
Lula R. Linder, "AD" House, Inc.
Janice Qualey, Coalition for Housing
Sonia Pellot, welfare recipient
Samantha Savacool, welfare recipient
Vilma Feliciano, welfare recipient
Rita Rodz, concerned citizen
Denise Dixon, Camden County Office of Economic Opportunity
Samuel Benison, concerned citizen
Mattie Parker, Camden County Office of Economic Opportunity
Casandra Copening, welfare recipient
Willie Simmons, Executive Vice-President of CWA Local 1081
Dennis Lysak, Saint Paul's Advocacy Group
Robyn Banks, welfare recipient
April Miller, Urban Women's Center
Joseph Ruffin, welfare recipient
Mike Feggigia, Interfaith Hospitality
Maria Heredia, Emergency Services for Families
Peter Kearney, Saint Paul's Advocacy Group
Myrna Bartee, General Assistance social case worker
Leroy Jones, Essex County Freeholder
Jack Johnson, Jr., welfare recipient
Connie Pascale, Legal Services of New Jersey

COMMENT: Several commenters expressed support for the concept, if not necessarily the level, set forth in the proposed standard of need. In particular, it was noted that "A realistic adjustment of the standard of need must be accomplished before we can begin any program of welfare reform which will help the poor in our state."

RESPONSE: The Department takes note of the comment.

COMMENT: The levels as proposed are inadequate due to the high rental costs. High rental costs coupled with lack of Section 8 subsidies "places the vast majority of recipients at risk." Inherent in any adjustment to the current standard of need is the obligation to consider the broad-based cost variance of housing in different locations throughout the State. The standard should be established in relationship to the "Fair Market Rents" and cost of living, particularly in higher cost of living indexed areas.

RESPONSE: Fair Market Rentals are calculated by the Federal Department of Housing and Urban Development and are based on rental costs for Metropolitan Statistical Areas (MSA'S) which include areas beyond New Jersey proper. Several New Jersey counties are included for this purpose in MSA's for Philadelphia, New York, and Wilmington, for example. Thus, rental costs derived for MSA's that include out of State cities cannot accurately reflect costs for individual New Jersey counties. In his December 6, 1990 letter to constituent groups concerning the standard of need, the Commissioner of Human Services stated that the proposed standard was an interim measure that will be reviewed and revised when housing cost data from the 1990 Census becomes available, thus permitting the determination of housing costs for New Jersey. Accordingly, the Department will take the matter under consideration with a view of future rulemaking.

COMMENT: Commenters urge that the Governor and Legislature recognize the long-standing under-funding of benefit levels and reinstate the 10 percent grant increase originally requested in the Department of Human Services budget. Commenters also suggest that the Department take the lead to urge the Legislature to appropriate adequate funds to support the standard of need.

RESPONSE: While the Department notes the concern of the commenters, it submits that this rulemaking deals specifically with the establishment of a standard of need rather than a particular benefit level that characterized the former request of the Department. To fund a grant level equal to the standard of need, as evidently submitted by some commenters, would necessitate separate rulemaking and be primarily contingent on legislative rather than executive activity.

COMMENT: The grant amounts should be raised to a level sufficient to secure and maintain housing for all recipients rather than to continue to expend the monies in emergency asisstance to the homeless. Assistance level increases are essential and central to welfare reform.

RESPONSE: The Department takes note of the observation, but points out that grant levels are issues apart from the formulation of the standard of need.

COMMENT: The Department of the Public Advocate requested that a public hearing be conducted on the proposed new rules.

RESPONSE: Pursuant to such request, the Department held hearings on the standard of need rulemaking on April 19, 1991 in Camden, East Orange and Trenton.

COMMENT: Several commenters noted that inadequate grant amounts have created a climate which encourages dishonesty, fraud, criminal behavior, and deception on the part of recipients. Held hostage by current grant levels, clients have become victims of economic deprivation.

RESPONSE: The Department takes note of the observation but submits that the setting of grant levels are issues apart from the formulation of the standard of need as embodied in this rulemaking.

COMMENT: A commenter noted that the "flat grant" concept must also be replaced.

RESPONSE: The Department takes note of the comment but points out that the flat grant or consolidated grant concept is an issue apart from the formulation of the standard of need and would be the subject of separate rulemaking activity.

COMMENT: Several commenters observed that the proposed standard of need defines clearly the wide discrepancy between current grant levels and what is actually needed to live in some measure of human dignity.

RESPONSE: The Department takes note of this observation.

COMMENT: A commenter urged the Department to complement income assistance with comprehensive programs to assist all New Jerseyans toward a decent standard of living.

RESPONSE: The Department takes note of the comment but points out that the establishment of such comprehensive programs are beyond issues that can be addressed within the confines of this rulemaking.

COMMENT: A commenter commends the Department for publishing an accurate standard of need and for involving advocates, researchers, and so forth, in its development.

RESPONSE: The Department takes note of such favorable comment.

COMMENT: One commenter suggested that upon adoption of the proposed standards, the Department should forward to the Legislature a detailed report on the standards and the consequences to recipients that result from existence of the difference between standards and payment levels.

RESPONSE: The Department takes note of the suggestion and will take the matter under deliberate consideration in the determination of a course of action to be pursued.

COMMENT: The Department should develop a short-term plan for implementing incremental increases in the benefit levels over each of the next few years, and immediately communicate that plan to the Legislature.

RESPONSE: The Department takes note of the comment but observes that welfare reform and assistance increase matters are issues apart from the formulation of the standard of need, the subject of this rulemaking.

COMMENT: The Department should commence an all-out effort to develop long-term reforms of our system of providing public assistance. The goal in such a reform effort must be to provide all families and individuals in our State with the basic supports they need to survive—shelter, food, medical care—and provide these basic supports in a way that encourages and facilitates, rather than impedes, entry into the workforce or job training programs.

RESPONSE: The Department submits, as previously indicated, that welfare reform is an issue apart from the formulation of the standard of need.

COMMENT: AFDC grant levels do not permit the rental of suitable housing and there are not enough rental subsidies available. According to the "Report on Emergency Assistance for AFDC Recipients" by the Department, December 12, 1990, 59 percent of all Board of Social Services clients pay more for rent than clients receive on welfare.

RESPONSE: The Department takes note of the comment, but as previously stated, submit that the establishment of the grant levels is an issue apart from the formulation of the standard of need.

COMMENT: The REACH program should be reevaluated as job training must be geared toward jobs that are available in a particular county. Additionally, job training should be for jobs other than minimal wage jobs.

RESPONSE: The Department observes that comments about the REACH program are issues not relevant to the formulation of the standard of need.

COMMENT: There should be more job-training, transportation, Medicaid and child care benefits available so clients can work.

RESPONSE: The Department notes that job training, Medicaid, transportation and child care are issues apart from the formulation of the standard of need.

COMMENT: The welfare system should be changed.

RESPONSE: The Department notes the generalized comment but submits that changing the welfare system is an issue apart from the formulation of the standard of need.

COMMENT: Temporary housing is becoming permanent housing for many recipients. Instead of giving motels large sums of money for temporary housing, that money should be invested in obtaining permanent housing.

RESPONSE: The Department takes note of the comment but submits that situations concerning temporary and permanent housing are issues apart from the formulation of the standard of need.

COMMENT: The system punishes recipients for working and encourages families to stay apart. The system penalizes a client for living with relatives and working.

RESPONSE: The Department takes note of the comments but indicates that the stated "punitive" aspects of the welfare system are issues apart from the formulation of the standard of need.

Full text of the adoption follows.

10:82-1.1A Standard of Need

New Jersey has established the following standards needed to maintain a safe and decent life. The Standard of Need specified below only serves as a benchmark set by the Commissioner, Department of Human Services, against which appropriations for funding the payment levels in the AFDC program may be determined.

Standard of Need

Number in Family	Monthly Standard
1	$ 410
2	$ 819
3	$ 985
4	$1,127
5	$1,260
6	$1,386
7	$1,505
8	$1,617
more than 8	add $112 each person

(a)

DIVISION OF ECONOMIC ASSISTANCE

General Assistance Program Standard of Need

Adopted Amendment: N.J.A.C. 10:85-4.1

Proposed: February 4, 1991 at 23 N.J.R. 286(a).
Adopted: November 25, 1991 by Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: November 26, 1991 as R.1992 d.2. **without change.**
Authority: N.J.S.A. 44:8-111(d).
Effective Date: January 6, 1992.
Operative Date: July 1, 1992.
Expiration Date: December 20, 1994.

Summary of Public Comments and Agency Responses:

Public hearings on the proposed amendments were held on April 19, 1991 in Camden, East Orange and Trenton, New Jersey. An Assistant Director acted as the hearing officer in each of the three sites. No formal recommendations were issued by the hearing officers in regard to the proposals. A copy of the public hearing records may be reviewed or obtained by contacting the Division of Economic Assistance, CN-716, Trenton, New Jersey 08625, or by phone at (609) 588-2289. As a result of these hearings the comment period was extended until May 6, 1991.

After reviewing the comments submitted, the Department is adopting the proposed amendments without change. The following individuals submitted written and/or oral comments:

Richard Preissler, Bergen County Board of Social Services
Wilfredo Caraballo, Department of the Public Advocate

COMMENT: Commenter supports the concept of the establishment of a standard of need.

RESPONSE: The Department takes note of the support expressed by the commenter.

COMMENT: Commenter feels that the levels as proposed are inadequate due to the high rental costs in Bergen County. High rental costs coupled with lack of Section 8 subsidies "places the vast majority of recipients at risk." The proposed standard of need should be modified to reflect the true market rentals of Bergen County.

RESPONSE: The Department takes note of the comment and points out that in his letter of December 6, 1990 to constituent groups concerning the standard of need, the Commissioner stated that the proposed standard is an interim measure that will be reviewed and updated when housing data from the 1990 census becomes available. That commitment will continue to be pursued.

COMMENT: Commenter urges the Governor and Legislature to recognize the long-standing underfunding of benefit levels and to reinstate the 10 percent grant increase originally requested in the Department of Human Services budget.

RESPONSE: While the Department notes the concern of the commenter, it submits that this rulemaking deals specifically with the establishment of a standard of need rather than a particular benefit level that characterized the former request of the Department. To fund a grant level equal to the standard of need, as advocatd by the commenter, would necessitate separate rulemaking and be primarily contingent on legislative rather than executive activity.

COMMENT: Commenter requests a public hearing.

RESPONSE: Pursuant to such request, the Department held hearings on the standad of need rulemaking on April 19, 1991 in Camden, East Orange and Trenton.

Full text of the adoption follows.

10:85-4.1 State and local responsibilities

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

(d) New Jersey has established the following standards needed to maintain a safe and decent life. The Standard of Need specified below only serves as a benchmark set by the Commissioner, Department of Human Services, against which appropriations for funding the payment levels in the GA program may be determined.

Standard of Need

Number of persons	Monthly Standard
1	$582
2	$739

CORRECTIONS

(a)

THE COMMISSIONER

Medical and Health Services Commitment for Psychiatric Treatment

Adopted New Rules: N.J.A.C. 10A:16-13

Proposed: June 17, 1991, at 23 N.J.R. 1890(a).
Adopted: December 11, 1991 by William H. Fauver, Commissioner, Department of Corrections, and Alan J. Gibbs, Commissioner, Department of Human Services.
Filed: December 11, 1991 as R.1992 d.23, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3(c)).

Authority: N.J.S.A. 30:1B-6; 30:1B-10; and 30:4-82.2.

Effective Date: January 6, 1992.
Expiration Date: April 6, 1992.

Summary of Public Comments and Agency Responses:

The Department of Corrections received comments from the Association for Children of New Jersey; the New Jersey Department of the Public Advocate; the County of Hunterdon, Department of Human Services; and Jean Paashaus, a private citizen. The comments and the Department of Corrections responses are as follows:

COMMENT: A commenter suggested that the rules be modified to describe a variety of mental health services or treatments in addition to psychiatric commitment. The commenter feels that the requirement set forth in N.J.A.C. 10A:16-13.3(a) to exhaust all reasonable means before utilizing the commitment process is too vague.

RESPONSE: It is not possible to explain in detail the psychiatric treatment services which may be utilized before commitment, because these services vary according to the resources and size of the parent correctional facility, and the classification status of the inmate. It is stated in N.J.A.C. 10A:16-13.3(b), however, that the management of symptoms is not limited to use of medication. The Division of Mental Health and Hospitals is working closely with the Department of Corrections to provide a full range of treatment modalities for the Capital Sentence Unit (C.S.U.) inmates at the New Jersey State Prison and for other inmates after their transfer to the Forensic Psychiatric Hospital. The choice of efficient and effective treatment is best left to the discretion of treating physicians and mental health professionals.

COMMENT: A commenter objected to the policy which mandates commitment of certain juveniles to the Forensic Psychiatric Hospital, especially without some directive as to clinically relevant services for this population. Commenter believes that this approach is not "appropriate" within the meaning of N.J.S.A. 30:4-82 et seq.

RESPONSE: It was not the intent of N.J.A.C. 10A:6-13.3 to mandate the commitment of all juveniles to the Forensic Psychiatric Hospital. In fact, it is the practice of the Department of Corrections to send those juveniles under 18 for whom commitment is the option of choice to Arthur Brisbane Child Treatment Center, and juveniles 18 years of age or older to Marlboro Psychiatric Hospital, whenever possible. For this reason, the language of N.J.A.C. 10A:16-13.3(c) will be changed to read "may" be hospitalized at the Forensic Psychiatric Hospital. It is important that commitment options remain open which will permit a choice of treatment locations which are appropriate not only clinically, but also to meet the security needs of persons affected.

COMMENT: A commenter asserted that the criteria for commitment do not meet the required legal definition of "dangerous to self or others," and should be revised to be consistent with current commitment law.

RESPONSE: The decision to order a person to be committed to a psychiatric facility is made by a court based on presentation of evidence to satisfy the legal standard. The criteria suggested in N.J.A.C. 10A:16-13.4 are symptoms which may singly or together result in causing a person to be dangerous to self or others. These criteria are consistent with the definition of "mental illness" found in N.J.S.A. 30:4-27.2r.

COMMENT: A commenter suggested that N.J.A.C. 10A:16-13.5(a)7 should be amended to read "severely disabling thought disorder," because it seems to be intended in the context of this section.

RESPONSE: The Department of Corrections agrees that "severely" is appropriate and will make this revision.

COMMENT: A commenter proposed that court rules for commitment of minors be included in N.J.A.C. 10A:16.

RESPONSE: This suggestion must be rejected. Court rules are easily accessible to the public and may be reviewed in the New Jersey State Law Library and county law libraries free of charge.

COMMENT: A commenter stated that N.J.A.C. 10A:16 fails to satisfy the mandate expressed in N.J.S.A. 30:4-82.1 et seq. to formulate procedures for providing mental health services to prison inmates, in accordance with a plan to be developed jointly by the Departments of Human Services and Corrections. The rules also omit procedures for biennial review and revision, as required by N.J.S.A. 30:4-82.2g.

RESPONSE: In N.J.A.C. 10A:16-13.3(a) and (b), it is indicated that all reasonable means be utilized to manage an inmate's psychiatric symptoms. Although not specifically expressed, the intent is that in those correctional facilities which have the resources of staff and space, modalities of treatment may include group and individual therapy, counselling, drug and alcohol therapy and any other reasonable treatment services which can be provided, including medication. Because the numerous correctional facilities in the State vary widely in their size, population and structure, it is impractical to mandate specific treatment modalities for all. Examples of treatment modalities which may be available at particular correctional facilities have been added to N.J.A.C. 10A:16-13.3. The rules, as proposed, have omitted a provision for biennial review. A new section N.J.A.C. 10A:16-13.14, requiring biennial review of these rules, has been added.

COMMENT: A commenter complained that N.J.A.C. 10A:16 will result in improper mixing of juveniles with adults, contrary to legal and professional standards.

RESPONSE: Despite the fact that N.J.A.C. 10A:16-13.3(c) may permit some juveniles to be housed at the Forensic Psychiatric Hospital, it does not, nor does the Department of Corrections intend to, utilize the Forensic Psychiatric Hospital (F.P.H.) for most juvenile commitments, regardless of their age or status.

As was mentioned above, whenever possible, juveniles under 18 years of age are sent to Arthur Brisbane Child Treatment Center and those 18 years of age or older go to Marlboro Psychiatric Hospital.

During 1990 and the first quarter of 1991, only one juvenile was committed to the Forensic Psychiatric Hospital. At the time of commitment he was 18 years of age. The Forensic Unit is used in those few cases which require enhanced security because of the individual's aggressive behavior and size or because a less restrictive environment is inappropriate.

COMMENT: A commenter objected to N.J.A.C. 10A:16-13.9(c)2 because it sets no specific time limit during which an inmate may be held at the Forensic Hospital while a Temporary Court Order is sought.

RESPONSE: The process of securing a Temporary Court Order is one which takes less than a day and does not result in the inmate having to remain overnight. Should there be any unforeseen delay in obtaining the Temporary Court Order, the correction officers, who are waiting at the Forensic Psychiatric Hospital, will transport the inmate back to the parent correctional facility. A statement clarifying this established practice will be added at N.J.A.C. 10A:16-13.9(c)3. It is intended that the Temporary Court Order be obtained immediately.

COMMENT: A commenter objected to N.J.A.C. 10A:16-13.8 which requires psychiatric treatment of the Capital Sentence Unit (C.S.U.) inmates to be conducted within the Capital Sentence Unit of the New Jersey State Prison. The commenter believes that the revised commitment law, N.J.S.A. 30:4-27.1 et seq., requires transfer to a psychiatric facility.

RESPONSE: The Department of Corrections believes that the commenter is mistaken. In *Matter of Savage,* 233 N.J. Super. 356 (App. Div. 1989), the court held that a prison inmate who has been sentenced to death can be committed to the Department of Human Services for psychiatric treatment without physical transfer. The inmate's treatment will be conducted by the Department of Human Services at the New Jersey State Prison, Capital Sentence Unit. This is consistent with the stringent security requirements set by the Legislature for the Capital Sentence Unit (C.S.U.).

COMMENT: A commenter suggested that a provision be included in N.J.A.C. 10A:16 for voluntary commitment.

RESPONSE: This is impractical in a prison setting and would produce an effort by many inmates to seek the less restrictive environment of a psychiatric facility. Prison inmates do not have the legal status which would permit such choice.

COMMENT: A commenter objected to the use of the term "unavailability of a psychiatrist" at N.J.A.C. 10A:16-13.9(c) because the commenter believes that it would result in unnecessary use of the community screening facilities and resources.

RESPONSE: The term "unavailable" is used to refer to smaller correctional facilities or county jails which do not have psychiatrists on staff or available on short notice as consultants. The rule will not result in unnecessary use of community screening services, because inmates may be transferred to correctional facilities which have ready access to mental health professionals and have set in place their procedures for commitment pursuant to N.J.A.C. 10A:16-13.7.

COMMENT: A commenter stated that community screening services should not be part of the correctional system psychiatric transfer rules because the use of community screening services would overburden the system and limit their availability for the local community.

RESPONSE: Community screening services will be used rarely by correctional facilities because the majority of correctional facilities which have inmates in need of commitment have mental health staff sufficient to utilize the commitment process spelled out by N.J.A.C. 10A:16-13.7. As such, there will be no adverse effect on community screening services.

Summary of Agency Initiated Change:

The Department of Corrections has changed N.J.A.C. 10A:16-13.11 to delete the words, "Screening service referrals for such inmates are not permitted." This is to avoid any confusion which might arise because of N.J.A.C. 10A:16-13.9 which refers to, "Screening service commitment of adult inmates." It should be clear that commitment of juveniles is governed only by the New Jersey Court Rule 4:74-7k (Pressler, N.J.)

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

CHAPTER 16
MEDICAL AND HEALTH SERVICES

SUBCHAPTER 13. COMMITMENT FOR PSYCHIATRIC TREATMENT

10A:16-13.1 Purpose and Scope

(a) The purpose of this subchapter is to provide for mental health services in State-owned or operated correctional facilities.

(b) This subchapter shall be applicable to all inmates assigned to correctional facilities within the Division of Adult Institutions or the Juvenile Medium Security Facility who are 18 years of age and older or juveniles who have been assigned adult status by the sentencing court.

10A:16-13.2 Definitions

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

"Department of Human Services" means the New Jersey Department of Human Services.

"Forensic Psychiatric Hospital" means the Forensic Psychiatric Hospital which is administered by the New Jersey Department of Human Services in Trenton, New Jersey.

"Licensed physician" means a person who has a valid and current license to practice medicine in the State of New Jersey (see N.J.A.C. 10A:16-2.4).

"Psychiatrist" means a physician who has completed the training requirements of the American Board of Psychiatry and Neurology and has a valid and current license to practice medicine in the State of New Jersey (see N.J.A.C. 10A:16-2.4).

"Screening Service" as defined in N.J.S.A. 30:4-27.2z.

10A:16-13.3 Psychiatric commitments

(a) Prior to considering the commitment of an inmate to the Forensic Psychiatric Hospital, the Chief Mental Health professional of the parent correctional facility shall have exhausted all reasonable means towards managing the inmate's psychiatric symptoms within the correctional facility.

(b) The management of the inmate symptoms shall include, but not be limited to*[,]***:***

1. Counselling;

2. Individual and/or group therapy;

3. Drug and alcohol therapy; and

4. *[encouraging]* ***Encouraging*** the inmate to take prescribed medication which has controlled said symptoms in the past.

(c) Sentenced adult inmates, inmates who are assigned to the Juvenile Medium Security Facility who are 18 years of age and older, or juveniles who have been assigned adult status by the sentencing court, *[shall]* ***may*** be hospitalized at the Forensic Psychiatric Hospital when:

1. They require psychiatric hospitalization;
2. They are assigned to housing units other than the Capital Sentence Unit;
3. They meet the admission, mental illness and security criteria set forth in N.J.A.C. 10A:16-13.4, 13.5 and 13.6; and
4. The appropriate commitment documents have been processed in accordance with the procedures outlined in this subchapter.

10A:16-13.4 Admission criteria

In order to be admitted to the Forensic Psychiatric Hospital, an inmate must exhibit symptoms or behavior from the categories of criteria listed in N.J.A.C. 10A:16-13.5 and 13.6.

10A:16-13.5 Mental illness criteria

(a) In order to meet the mental illness criteria for commitment to the Forensic Psychiatric Hospital, the inmate must exhibit one or more of the following:

1. Hallucinations (visual or auditory);
2. Delusions motivating or commanding patient to harm self or others or to perform dangerous behavior;
3. Acute psychotic episodes or acute exacerbation of psychotic symptoms from previously diagnosed psychosis (recent onset within 10 days);
4. Bizarre behavior, agitation, psychomotor retardation or depression markedly interfering with daily function, which causes severe subjective distress or is grossly socially unacceptable;
5. Total body rigidity or immobility (catatonia);
6. Severe and disabling anxiety; and/or
7. *[Disabling]* ***Severely disabling*** thought disorder.

10A:16-13.6 Security criteria

(a) In order to meet the security criteria for commitment to the Forensic Psychiatric Hospital, the inmate must be a danger to self, others or property as evidenced by one or more of the following:

1. A suicide attempt within the past seven days;
2. Persistent suicide ideation;
3. Assaultive/harmful behavior;
4. Verbal threats to harm others;
5. Arson;
6. Self-mutilative behavior or threats;
7. Hallucinations (visual or auditory);
8. Delusion motivating or commanding patient to harm self or others or to perform dangerous behavior; and/or
9. Paranoid hallucinations/delusions so severe that patient is unable to perform basic care needs, such as:
   i. Eating;
   ii. Drinking; and/or
   iii. Personal hygiene.
10. Severe psychiatric condition unresponsive to treatment with medication (at least three weeks duration) and admitted for intensive medication trial;
11. Problems which require special treatment procedures such as seclusion/restraint in a maximum security treatment setting;
12. Psychiatric problems, which require close supervision due to associated medical conditions when the medical condition is stabilized and the psychiatric problems outweigh strictly medical intervention; and/or
13. Psychiatric decompensation due to medication refusal while in a State correctional facility.

10A:16-13.7 Regular commitment of adult inmates to the Forensic Psychiatric Hospital

(a) Copies of the appropriate forms shall be used when the inmate, who is assigned to a housing unit other than the Capital Sentence Unit (C.S.U.), is being committed to the Forensic Psychiatric Hospital.

(b) Form DHS—C4 APPLICATION FOR TEMPORARY COMMITMENT shall be used for the commitment of an inmate(s) and shall be completed and signed by the Superintendent or Acting Superintendent.

(c) Two practicing physicians, one of whom must be a licensed psychiatrist, shall each complete a CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS Form.

(d) The physician and psychiatrist who complete the two CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS Forms may not be related by blood or marriage to the inmate, nor be the director, chief executive officer or proprietor of any institution for the care and treatment of the mentally ill to which certification for admission of the inmate is being made.

(e) The TEMPORARY ORDER FOR COMMITMENT Form shall be signed by the Superintendent or his or her designee and shall be presented, by a representative of the sending correctional facility, to a judge for signature. After the judge has signed the Temporary Order, the Temporary Order shall be taken together with the certifications, and the inmate to the Forensic Psychiatric Hospital.

(f) In all cases, the Forensic Psychiatric Hospital shall be contacted prior to transporting an inmate to that facility for a psychiatric examination or for admission.

(g) The originals of the completed forms DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT, CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS, and TEMPORARY ORDER FOR COMMITMENT shall be left with the Forensic Psychiatric Hospital and the psychiatric facility shall file these documents for the final hearing. The correctional facility shall maintain a copy of all these completed forms in the inmate's medical folder.

(h) The correctional facility shall receive notice of the final hearing but it will not be necessary for a correctional facility staff member to attend unless the attorney representing the State indicates that attendance is necessary.

10A:16-13.8 Psychiatric treatment in the Capital Sentence Unit (C.S.U.)

(a) Inmates assigned to the Capital Sentence Unit (C.S.U.) at the New Jersey State Prison shall receive psychiatric treatment at the New Jersey State Prison in accordance with the New Jersey Department of Corrections and the New Jersey Department of Human Services agreement pursuant to said inmates.

(b) Form DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT shall be completed and signed by the Superintendent of the New Jersey State Prison.

(c) Two practicing physicians, one of whom must be a licensed psychiatrist, shall each complete a CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS Form.

(d) The physician and psychiatrist who complete the two CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS Forms may not be related by blood or marriage to the inmate, nor be the director, chief executive officer or proprietor of any institution for the care and treatment of the mentally ill to which certification for admission of the inmate is being made.

(e) The TEMPORARY ORDER FOR COMMITMENT Form for inmates assigned to the Capital Sentence Unit (C.S.U.) shall be presented to a judge for signature. After the judge has signed the Temporary Order, the inmate will receive psychiatric treatment within the New Jersey State Prison.

(f) The originals of the completed DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT, CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS and the TEMPORARY ORDER FOR COMMITMENT Forms shall be used by the New Jersey State Prison to file for the final hearing.

10A:16-13.9 Screening service commitment of adult inmates

(a) Copies of the appropriate forms shall be used when an adult inmate, who is assigned to a housing unit other than the Capital Sentence Unit (C.S.U.), is being transferred to the Forensic Psychiatric Hospital for emergency psychiatric treatment.

(b) Form DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT shall be used for the commitment of the inmate and shall be completed and signed by the Superintendent or Acting Superintendent. A clear delineation of the treatment efforts the correctional facility has attempted and the current behavior of the inmate which justifies admission for treatment shall be included in information provided on Form DHS-C4.

(c) In a situation involving an inmate assigned to a housing unit other than the Capital Sentence Unit (C.S.U.) and the unavailability of a psychiatrist to complete a Clinical/Screening Certificate, the following procedures shall be utilized as appropriate:

1. If the local Division of Mental Health and Hospitals' (D.M.H.&H.) designated Screening Service has been approved for this purpose by the D.M.H.&H.'s Division Director, the correctional staff shall contact that Screening Service pursuant to N.J.S.A. 30:4-27.1 et seq. (Screening Law). The Screening Service shall provide a screening evaluation either at the correctional facility or the Screening Service site. If the inmate meets the commitment standard, the Screening Service shall complete the Clinical/Screening Certificate and the New Jersey Department of Corrections shall transport the inmate to and from the Screening Service and to the Forensic Psychiatric Hospital, if necessary, or

2. If the local D.M.H.&H.'s designated Screening Service has not been approved for this purpose by the D.M.H.&H.'s Division Director, the correctional staff shall contact the Forensic Psychiatric Hospital prior to transporting the inmate to that hospital for screening. A physician employed by the Department of Corrections shall complete a Clinical/Screening Certificate and the Application for Temporary Commitment shall be completed and signed by the Superintendent or Acting Superintendent. Both of these documents shall accompany the inmate when transported to the Forensic Psychiatric Hospital. Correctional staff shall wait at the Forensic Psychiatric Hospital while the inmate is being screened. If the inmate meets the commitment standard, a psychiatrist employed by the Forensic Psychiatric Hospital shall complete the Clinical/Screening Certificate and correctional staff shall obtain a Temporary Court Order to finalize the involuntary commitment. The inmate shall remain in custody at the Forensic Psychiatric Hospital while the Temporary Court Order is being secured but not be admitted as an involuntarily committed patient until the court issues a Temporary Court Order.

3. If there is an unforeseen delay in obtaining a Temporary Court Order which would result in an overnight stay by the inmate at the Forensic Psychiatric Hospital, the correction officers shall transport the inmate back to the parent correctional facility.

(d) The TEMPORARY ORDER FOR COMMITMENT form shall be presented, by a representative of the sending correctional facility, to a judge for signature. After the judge has signed the Temporary Order, the Temporary Order shall be taken together with the certifications to the Forensic Psychiatric Hospital.

(e) In all cases, the Forensic Psychiatric Hospital shall be contacted prior to transporting an inmate to that facility for admission.

(f) The originals of the completed forms DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT, CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS, and TEMPORARY ORDER FOR COMMITMENT shall be left with the Forensic Psychiatric Hospital and the psychiatric facility shall file these docu-

ments for the final hearing. The correctional facility shall maintain a copy of all these forms on file.

(g) The correctional facility shall receive notice of the final hearing, but it will not be necessary for a correctional facility staff member to attend unless the attorney representing the State indicates that attendance is necessary.

10A:16-13.10 Listing of local mental health screening services

The Office of Institutional Support Services shall maintain an up-to-date listing of designated local mental health screening services, approved to perform inmate screenings, which shall be available to all correctional facilities within the Department of Corrections.

10A:16-13.11 Commitment of inmates under *[eighteen]* **18** years of age

(a) Whenever an inmate under *[eighteen]* **18** years of age is in need of involuntary commitment, the procedures contained in Pressler, N.J. Court Rules, Rule 4:74-7k, shall be followed. *[Screening service referrals for such inmates are not permitted.]*

(b) In conjunction with (a) above, the procedures outlined in N.J.A.C. 10A:16-13.7 shall be utilized for inmates under eighteen years of age with the exception of the forms. The APPLICATION FOR TEMPORARY COMMITMENT, CERTIFICATE FOR INVOLUNTARY COMMITMENT OF MINORS (DHS-Al-Rev. 6/89) and the TEMPORARY ORDER FOR INVOLUNTARY COMMITMENT OF A MINOR shall be utilized for such commitments.

10A:16-13.12 Transportation

(a) Transportation to and from the Forensic Psychiatric Hospital shall be provided by the New Jersey Department of Corrections.

(b) Inmates in the Forensic Psychiatric Hospital requiring transportation for court appearances or medical transfer to outside medical facilities shall be provided with a New Jersey Department of Corrections escort coordinated by the Office of Central Medical/Transportation, Department of Corrections.

(c) Within 48 hours of the Forensic Psychiatric Hospital notification of the sending correctional facility that the inmate has been discharged, the New Jersey Department of Corrections shall transport the inmate to the sending correctional facility.

***10A:16-13.13 Review and revision of rules**

The Commissioners of the Departments of Human Services and Corrections or their designees shall meet two years from the adoption of these rules and every two years thereafter to review the procedures set forth in these rules and to determine the need for any revisions.*

10A:16-*[13.13]***13.14*** Forms

(a) The following forms related to psychiatric transfers shall be reproduced by each correctional facility from originals that are available by contacting the New Jersey Department of Human Services, Division of Mental Health and Hospitals, or the Office of Institutional Support Services (O.I.S.S.), Health Services Unit, New Jersey Department of Corrections.

1. DHS-C4 APPLICATION FOR TEMPORARY COMMITMENT;
2. CLINICAL/SCREENING CERTIFICATE OF INVOLUNTARY COMMITMENT OF MENTALLY ILL ADULTS;
3. TEMPORARY ORDER FOR COMMITMENT;
4. CERTIFICATE FOR INVOLUNTARY COMMITMENT OF MINORS; and
5. TEMPORARY ORDER FOR INVOLUNTARY COMMITMENT OF A MINOR.

(a)

THE COMMISSIONER

Mail, Visits and Telephone
Identification of Sender of Outgoing Correspondence
Adopted Amendment: N.J.A.C. 10A:18-2.9

Proposed: August 19, 1991 at 23 N.J.R. 2468(a).
Adopted: November 22, 1991 by William H. Fauver, Commissioner, Department of Corrections.
Filed: November 26, 1991 as R.1992 d.3, **without change.**

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Effective Date: January 6, 1992.
Expiration Date: July 6, 1992.

Summary of Public Comments and Agency Responses:

The Department of Corrections received 32 comments on this proposal from the following individuals: Louis Zeltner, Montclair, New Jersey; Mary Hefferman, Bloomfield, New Jersey; Randall Enterline, Trenton, New Jersey; John Paff, Somerset, New Jersey; Madeline and Peter Joslin, South Jersey; JoAnn Hart, Wall, New Jersey; Mrs. Paul Parrone, Sr., Kilmer, New Jersey; David Drukaroff, Lakewood, New Jersey; Grace Biddle, Bordentown, New Jersey; James Curley, Adult Diagnostic and Treatment Center (A.D.T.C.); Fred Frank, A.D.T.C.; Alexander Olin, A.D.T.C.; Douglas Lear, A.D.T.C.; Gregory McMillion, A.D.T.C.; Donald Manigold, A.D.T.C.; Edward Stafford, A.D.T.C.; Richard Maiello, A.D.T.C.; Herman Espada, A.D.T.C.; Paul Lafferty, A.D.T.C.; Paul Parrone, A.D.T.C.; Thomas Cervelli, A.D.T.C.; Jay Hass, A.D.T.C.; Bill Szatkiewicz, A.D.T.C.; Kenneth Walker, A.D.T.C.; Andrew Toohey, A.D.T.C.; John Sileo, A.D.T.C.; Bob Kleiman, A.D.T.C.; Kenneth Pursell, A.D.T.C.; Frederick Hart, A.D.T.C.; Bruce Morrison, A.D.T.C.; Casimir Usowicz, Southern State Correctional Facility.

COMMENT: One commenter wrote to support the proposal. She stated that this rule will inform merchants and individuals when receiving correspondence from an inmate and will "undoubtedly prevent their becoming victims of fraud and other undesirable situations."

Nine comments were received from various community persons in opposition to the proposed amendment. These included relatives or friends of inmates, clergy and professional persons, including one Certified Public Accountant (C.P.A.). These commenters made two arguments:

1. That merchants should themselves take the responsibility for checking on sources and identities of persons who place orders for merchandise, rather than unduly relying on the Department of Corrections to do this for them. It is the merchants' own business practices which place the businesses at risk for fraudulent orders; and
2. That many persons who correspond with prison inmates would experience shame and embarassment if their friends or neighbors became aware of the source of their correspondence. In particular, children or elderly relatives might suffer especially by becoming aware that the sender of the correspondence is incarcerated. This policy will result in unfair "punishment" of innocent persons in the community.

Twenty-two prison inmates expressed opposition to the proposal, one from Southern State Correctional Facility and 21 from the Adult Diagnostic and Treatment Center (A.D.T.C.). The following reasons were cited:

1. Shame and embarassment caused to inmates' families and friends;
2. Invasion of privacy of recipients;
3. Adverse impact on correspondence caused by embarrassment, which may also interefere with rehabilitation;
4. Punishment of innocent persons in the community because of misbehavior of a few inmates;
5. Merchants lulled into a false sense of security by the regulation; and
6. Policy should be limited to mail sent to merchants.

RESPONSE: Taking the last mentioned comment first, it would not be practical or cost-effective to attempt to apply this policy only to mail addressed to merchants. Fraudulent activities by prison inmates are perpetrated against members of the public as well as against merchants. Also, correction officers in the mail room would not be able to inspect and recognize the names of merchants in every case. This method of handling the problem would prove to be both costly and unreliable.

The Department of Corrections agrees that merchants should themselves be more careful in readily filling orders received by mail, but this does not mean that the Department of Corrections should simply "look the other way." It is also the responsibility of the Department of Corrections to protect the public in every way possible from fraud or other illicit activities sought to be carried out by inmates through correspondence.

The Department of Corrections is not insensitive to the frustration or pain which this policy may cause to some relatives or friends of inmates. But it is the inmates' actions resulting in their sentences which caused the situations of which they complain. The Department of Corrections has no desire to embarrass persons in the community; on the contrary, the Department of Corrections seeks to protect the community from further, unnecessary victimization.

It is anticipated that rather than to discourage correspondence with friends and relatives, this policy will encourage inmates to interact more realistically with persons in the community so as to appreciate all the consequences of their criminal behavior and make genuine efforts towards rehabilitation. Thus, although in the short term some persons may experience discomfort, in the long term there will be more positive benefits.

Full text of the adoption follows:

10A:18-2.9 Identification of sender of outgoing correspondence

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

(d) The full name of the correctional facility shall be clearly stamped or printed in the upper left corner of all outgoing envelopes from inmates.

LAW AND PUBLIC SAFETY

(a)

DIVISION OF MOTOR VEHICLES

Persian Gulf War Commemorative License Plates

Adopted New Rules: N.J.A.C. 13:20-41

Proposed: October 7, 1991 at 23 N.J.R. 2916(a).
Adopted: November 25, 1991 by Stratton C. Lee, Jr., Director, Division of Motor Vehicles.
Filed: December 10, 1991 as R.1992 d.20, **without change.**

Authority: P.L. 1991, c.264, §1.

Effective Date: January 6, 1992.
Expiration Date: December 13, 1995.

Summary of Public Comments and Agency Responses:

Opportunity to be heard with regard to the proposal was invited via notice published in the October 7, 1991 New Jersey Register. A media advisory was also prepared by the Division of Motor Vehicles with regard to the proposal. **No comments were received** from the public with regard to the proposal.

Full text of the adoption follows.

SUBCHAPTER 41. PERSIAN GULF WAR COMMEMORATIVE LICENSE PLATES

13:20-41.1 Definition

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

"Division" means the Division of Motor Vehicles in the Department of Law and Public Safety.

"Nonprofit organization" means:

1. Any nonprofit organization dedicated to celebrating or commemorating the Persian Gulf War or aiding the participants or their families; or

2. Any nonprofit organization dedicated to establishing or maintaining a memorial to any war.

13:20-41.2 Fees

(a) The Division of Motor Vehicles shall charge a fee of $3.00 per plate for Persian Gulf War commemorative license plates which it issues to nonprofit organizations pursuant to subsection (a) of section 1 of P.L. 1991, c.264. The commemorative license plates shall be issued by the Division only in multiples of 50.

(b) Nonprofit organizations which are issued Persian Gulf War commemorative license plates by the Division of Motor Vehicles pursuant to subsection (a) of section 1 of P.L. 1991, c.264 may sell such plates at a fee of $10.00 per plate up to and including January 31, 1992, and not more than $10.00 per plate thereafter.

13:20-41.3 Display

(a) Persian Gulf War commemorative license plates may be displayed on a New Jersey registered vehicle in accordance with subsection (b) of section 1 of P.L. 1991, c.264 and this subchapter from October 1, 1991 until April 1, 1992.

(b) The commemorative license plate shall be mounted on the front of the New Jersey registered vehicle at the same location as the regular front license plate, which shall be removed from the vehicle immediately prior to the mounting of the commemorative license plate. The regular front license plate shall remain mounted on those vehicles which do not display the commemorative license plate.

(c) After the last day during which the commemorative license plate may be displayed on a vehicle pursuant to subsection (b) of section 1 of P.L. 1991, c.264, the commemorative license plate may no longer be displayed in place of the regular front license plate, and the regular front license plate shall be immediately re-mounted on the front of the vehicle at the same location where it had previously been mounted.

13:20-41.4 Complaints; investigations

The Division shall, through its employees during regular business hours, be available to receive complaints from the public regarding the sale of Persian Gulf War commemorative license plates to the public pursuant to P.L. 1991, c.264 and this subchapter. The Division may conduct such investigations into the sale of the commemorative license platees as it deems necessary and proper.

(b)

NEW JERSEY RACING COMMISSION

Thoroughbred Rules

Administering Medication to Respiratory Bleeders

Adopted Amendment: N.J.A.C. 13:70-14A.9

Proposed: October 7, 1991 at 23 N.J.R. 2919(c).
Adopted: November 21, 1991 by the New Jersey Racing Commission, Bruce H. Garland, Executive Director.
Filed: December 10, 1991 as R.1992 d.19, **without change.**

Authority: N.J.S.A. 5:5-30.

Effective Date: January 6, 1992.
Expiration Date: January 25, 1995.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

13:70-14A.9 Administering medication to respiratory bleeders

(a) The stewards may permit the administration of medication to control respiratory bleeding in animals that:

1.-2. (No change.)

3. Are observed in New Jersey to bleed during the running or driving of a workout or race at a duly licensed New Jersey racetrack, or in the detention barn following such workout or race by the State or Associate State Veterinarian and have been placed on a veterinarian's list for at least 10 days; or

4. (No change.)

(b)-(e) (No change.)

(a)

NEW JERSEY RACING COMMISSION

Harness Rules
Administering Medication to Respiratory Bleeders
Adopted Amendment: N.J.A.C. 13:71-23.8

Proposed: October 7, 1991 at 23 N.J.R. 2919(d).
Adopted: November 21, 1991 by the New Jersey Racing Commission, Bruce H. Garland, Executive Director.
Filed: December 10, 1991 as R.1992 d.18, **without change.**

Authority: N.J.S.A. 5:5-30.

Effective Date: January 6, 1992.
Expiration Date: January 25, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

13:71-23.8 Administering medication to respiratory bleeders

(a) The judges may permit the administration of medication to control bleeding in animals that:

1. (No change.)

2. Are observed in New Jersey to bleed during the running or driving or a workout or race at a duly licensed New Jersey racetrack, or in the detention barn following such workout or race by the State or Associate State Veterinarian and have been placed on a veterinarian's list for at least 10 days; or

3. (No change.)

(b)-(e) (No change.)

TREASURY-GENERAL

(b)

DIVISION OF PENSIONS

State Police Retirement System
Methods of Repayment
Adopted Amendment: N.J.A.C. 17:5-4.3

Proposed: June 17, 1991, at 23 N.J.R. 1896(b).
Adopted: November 27, 1991, by the State Police Retirement System, Michael Weik, Secretary.
Filed: December 2, 1991 as R.1992 d.4, **without change.**

Authority: N.J.S.A. 53:5A-30h

Effective Date: January 6, 1992.
Expiration Date: November 30, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

17:5-4.3 Methods of repayment

(a) Methods of repayment include the following:

1.-2. (No change.)

3. Extra deductions equal to at least one-half of the full regular pension deduction for a maximum period of 10 years;

4. (No change.)

OTHER AGENCIES

(c)

CASINO CONTROL COMMISSION

Proceedings Against Licensees
Underage Gaming Violations
Affirmative Defenses
Adopted New Rules: N.J.A.C. 19:42-5.9 and 5.10

Proposed: October 21, 1991 at 23 N.J.R. 3084(a).
Adopted: December 5, 1991 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: December 5, 1991, as R.1992 d.12, **without change.**

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(q) and 119.

Effective Date: January 6, 1992.
Expiration Date: May 12, 1993.

Summary of Public Comment and Agency Response:
COMMENT: One comment was received from the Division of Gaming Enforcement, which supported the adoption of the proposed rules.
RESPONSE: Accepted.

Full text of the adoption follows.

19:42-5.9 Underage gaming—violations

(a) No casino licensee or agent or employee thereof, shall allow, permit or suffer any person under the age at which a person is authorized to purchase and consume alcoholic beverages in this State ("underage person") to:

1. Enter a casino, except to pass directly to another room, unless the underage person is licensed under the Act and is acting in the regular course of his or her licensed activities;

2. Remain in a casino, unless the underage person is licensed under the Act and is acting in the regular course of his or her licensed activities;

3. Gamble in a casino;

4. Be rated as a player;

5. Receive complimentary services or items as a result of, or in anticipation of, his or her gaming activity; or

6. Utilize credit.

(b) No casino licensee or agent or employee thereof, shall approve a credit limit for an underage person, pursuant to N.J.A.C. 19:45-1.27(b).

(c) Each violation of any of the provisions of (a) or (b) above as to a single underage person shall be considered a separate and distinct violation for purposes of N.J.S.A. 5:12-129.

(d) Each employee and agent of a casino licensee shall have an affirmative obligation to ensure that no underage persons engage in any of the activities listed in (a) above. Each employee or agent of a casino licensee who violates any provision of this section may be held jointly or severally liable for any such violation.

19:42-5.10 Underage gaming violations—affirmative defenses

(a) No casino licensee or employee or agent thereof shall be held liable for any violation of N.J.S.A. 5:12-119 and N.J.A.C. 19:42-5.9 if such person can establish the affirmative defense authorized by N.J.S.A. 5:12-119(b).

(b) For purposes of establishing an affirmative defense to a violation of N.J.S.A. 5:12-119 and N.J.A.C. 19:42-5.9, the term "writing" in N.J.S.A. 5:12-119(b) shall include the following:

1. A photographic driver's license;

2. A photographic identification card issued pursuant to N.J.S.A. 33:1-81.2, or a similar card issued pursuant to the laws of another state or the Federal government; or

3. A writing which is made and signed by the underage person, and which contains, at a minimum, the following information:

i. The name, address, age and date of birth of the person; and

ii. A statement that the representation of age is being made to induce the licensee to permit the person to enter, remain or gamble in a casino, to be rated, receive complimentaries, obtain approval of a credit limit, or to utilize credit.

(a)

CASINO CONTROL COMMISSION

Accounting and Internal Controls
Procedure for Exchange of Checks Submitted by Gaming Patrons

Adopted Amendment: N.J.A.C. 19:45-1.25

Proposed: October 21, 1991 at 23 N.J.R. 3087(a).
Adopted: December 5, 1991 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: December 5, 1991, as R.1992 d.13, **without change.**

Authority: N.J.S.A. 5:12-63(c), 69(a), 70(g) and (1), 99(a)(13) and 101(g).

Effective Date: January 6, 1992.
Expiration Date: March 24, 1993.

Summary of Public Comments and Agency Responses:
COMMENT: The Division of Gaming Enforcement and the Sands Hotel, Casino and Country Club indicated that they supported the proposed amendment.
RESPONSE: Accepted.

Full text of the adoption follows.

19:45-1.25 Procedure for exchange of checks submitted by gaming patrons

(a)-(g) (No change.)

(h) A general cashier of the New Jersey casino which issued the casino check shall provide such information, as required by (f) above, to the casino licensee accepting such check and shall indicate that verification was requested by notating in a log the following information:

1.-6. (No change.)
7. The reason for the check as either:
i. The return of a patron's deposit money;
ii. The redemption of the casino's gaming chips; or
iii. The winnings from slot machine payoffs.

(i)-(p) (No change.)

(b)

CASINO CONTROL COMMISSION

Casino Hotel Alcoholic Beverage Control

Adopted Amendments: N.J.A.C. 19:50

Proposed: October 21, 1991 at 23 N.J.R. 3087(b).
Adopted: December 5, 1991 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: December 5, 1991 as R.1992 d.14, **without change.**

Authority: N.J.S.A. 5:12-69(a), 70(q) and 103(e).

Effective Date: January 6, 1992.
Expiration Date: May 12, 1993.

Summary of Public Comments and Agency Responses:
COMMENT: Harrah's Casino Hotel indicated that it supports the proposed amendments with the exception of N.J.A.C. 19:50-1.2(b). It believes that this subsection would lead to unnecessary delays in the regulatory approval process, because it would require a CHAB licensee to submit its filings to the State Division of Alcoholic Beverage Control (State ABC) as well as the Commission in all cases.

RESPONSE: N.J.A.C. 19:50-1.2(b) does not require dual filings in all cases. CHAB licensees must file submissions with the State ABC only when such filings are required by Title 33 of the Revised Statutes or Title 13 of the New Jersey Administrative Code. The Commission does not require that submissions filed with the Commission pursuant to N.J.A.C. 19:50 also be submitted to the State ABC. The purpose of the rule is to apprise the Commission of submissions to the State ABC which may lie outside the Commission's alcoholic beverage jurisdiction, but which may impact upon a CHAB licensee's operation, such as off-site storage warehouses or retail transit permits for limousines and vessels operated by a CHAB licensee. In the Commission's opinion, this filing requirement, which was contained in the original CHAB regulations, is still necessary and should be retained.

COMMENT: The Division of Gaming Enforcement indicated that it supports the proposal.
RESPONSE: Accepted.

Full text of the adoption follows.

SUBCHAPTER 1. GENERAL PROVISIONS

19:50-1.1 Definitions

(a) For the purposes of this chapter, words shall be defined in accordance with the Act, the regulations of the Commission, Title 33 of the Revised Statutes (N.J.S.A. 33:1-1 et seq.), Title 13 of the New Jersey Administrative Code (N.J.A.C. 13:2) or according to their commonly understood meaning or usage except where such common meaning or usage would be inconsistent with the purpose or intent of the Act. Any definition contained herein or incorporated by reference shall apply to any form of the defined word. For example, "sell" means to make a "sale" as defined in N.J.S.A. 33:1-1(w).

(b) Where definitions set forth in the Act or Commission regulations conflict with those contained in Title 33 of the Revised Statutes or Title 13 of the New Jersey Administrative Code, the definitions contained in the Act or Commission regulations shall govern.

(c) For the purposes of this chapter, the following definitions shall apply:

"Alcohol" is defined in N.J.S.A. 33:1-1(a).

"Alcoholic beverage" is defined in N.J.S.A. 33:1-1(b).

"Authorized location" means any room or area which is in, on, or about the premises, and which has been approved by the Commission for the service, sale, consumption, or storage of alcoholic beverages pursuant to N.J.S.A. 5:12-103 and this chapter.

"Casino hotel alcoholic beverage (CHAB) licensee" means a person licensed to serve, sell or store alcoholic beverages pursuant to N.J.S.A. 5:12-103 and this chapter.

"Container" is defined in N.J.S.A. 33:1-1(e).

"Manufacturer" is defined in N.J.S.A. 33:1-1(m).

"Original container" means any container in which an alcoholic beverage has been delivered to a CHAB licensee.

"Premises" means the premises licensed as an approved hotel pursuant to N.J.S.A. 5:12-27.

"Retailer" is defined in N.J.S.A. 33:1-1(u).

"Sale" is defined in N.J.S.A. 33:17-1(w).

"Wholesaler" means any person who sells an alcoholic beverage for the purpose of resale to a licensed wholesaler, a licensed retailer, or a CHAB licensee.

19:50-1.2 Applicability of other laws

(a) Title 33 of the Revised Statutes and the rules, regulations and bulletins promulgated thereunder by the Director of the Division of Alcoholic Beverage Control shall, except as otherwise provided in section 103 of the Act or this chapter, apply to any premises and to any CHAB licensee.

(b) All CHAB licensees that are required to make informational and other filings by Title 33 of the Revised Statutes and Title 13 of the New Jersey Administrative Code shall make all such filings both to the Commission, in accordance with prescribed procedures, and to the Division of Alcoholic Beverage Control.

(c) A CHAB licensee engaging in off-premises storage, delivery or sale of alcoholic beverages shall obtain any necessary licenses or permits for such activities from the Division of Alcoholic Beverage Control. If these alcoholic beverage activities are in any way connected with or involve the licensed premises, copies of these licenses or permits shall be submitted to the Commission within three business days of their receipt by the licensee.

(d) Any licensed wholesaler or other person who has obtained a merchandising permit from the Division of Alcoholic Beverage Control to offer complimentary samples of alcoholic beverages on a CHAB licensee's premises, need not obtain a CHAB license or permit from the Commission in order to conduct such activity in a CHAB authorized location; provided, however, that a copy of such

permit shall be submitted to the Commission at least three business days prior to the event, and shall be displayed at the event itself.

19:50-1.3 License and authorization as conditions precedent to operation

(a) No casino licensee, nor any of its lessees, agents or employees, nor any other person except as otherwise provided in this chapter, shall expose for sale, solicit or promote the sale of, possess with intent to sell, sell, give, dispense, or otherwise transfer or dispose of alcoholic beverages in, on or about the premises unless such person possesses a CHAB license.

(b) No CHAB licensee, nor any of its agents or employees, shall expose for sale, solicit or promote the sale of, possess with intent to sell, sell, give, dispense or otherwise transfer or dispose of alcoholic beverages except in an authorized location.

(c) (No change.)

(d) A CHAB license shall be granted for a term which coincides with the term of the casino license or casino service industry license held by the licensee.

19:50-1.4 Classification of authorized locations

(a) Authorized locations shall be classified as follows:

1. All locations authorized pursuant to N.J.S.A. 5:12-103(g)(1) shall be classified as Type I (casino) locations.

2. All locations authorized pursuant to N.J.S.A. 5:12-103(g)(2) shall be classified as Type II (hotel) locations.

3. All locations authorized pursuant to N.J.S.A. 5:12-103(g)(3) shall be classified as Type III (packaged goods) locations.

4. All locations authorized pursuant to N.J.S.A. 5:12-103(g)(4) shall be classified as Type IV (room service) locations.

5. All locations authorized pursuant to N.J.S.A. 5:12-103(g)(5) shall be classified as Type V (storage) locations.

(b) The activities permitted in each type of authorized location, subject to applicable laws, rules, and regulations, are as follows:

1. (No change.)

2. In a Type II location, a CHAB licensee shall be entitled to sell any alcoholic beverage by the glass or other open receptacle for on-premises consumption within a casino hotel but not in a casino, or from fixed locations outside a casino hotel, but on a casino hotel premises. Examples of Type II locations include, without limitation, showrooms, cabarets, restaurants, meeting rooms, pubs and lounges.

3. In a Type III location, a CHAB licensee shall be entitled to sell any alcoholic beverage in original containers from an enclosed package goods room, not in a casino, for consumption outside the authorized location.

4. In a Type IV location, a CHAB licensee shall be entitled to sell any alcoholic beverage from a room service location within an enclosed room, not in a casino, for delivery to a guest room or to any other room in the premises authorized by the Commission, other than a Type I, III or V location.

5. In a Type V location, a CHAB licensee shall be entitled to possess or to store in a fixed location on the premises, not in a casino, alcoholic beverages intended but not actually exposed for sale.

(c) Notwithstanding any other provision of this chapter to the contrary, a CHAB licensee shall be entitled to possess or store within any of its authorized locations alcoholic beverages intended but not actually exposed for sale in that authorized location, without obtaining a separate or additional Type V location authorization.

(d) The Commission may, consistent with the requirements of (b) above, issue two or more types of authorizations for the same authorized location, or different types of authorizations for different areas of the same authorized location. This subsection shall not apply to Type I or Type V authorized locations.

19:50-1.5 Standards for qualification

(a) (No change.)

(b) No CHAB license which authorizes the sale of alcoholic beverages within a casino shall issue to any applicant who does not hold a casino license issued pursuant to the Act.

(c) No CHAB license which authorizes the possession, sale or storage of alcoholic beverages within any part of the premises, other than a casino, shall issue to any applicant who would not qualify under the standards for licensure of a non-gaming related casino service industry pursuant to N.J.S.A. 5:12-92(c).

(d) No Type V authorization shall issue to any applicant who does not hold a Type I, II, III or IV CHAB authorization.

(e) Every employee and agent of a CHAB licensee whose employment or agency includes duties in, on, or about the premises, but not in a Type I authorized location, shall be registered as a casino hotel employee in accordance with section 91 of the Act.

(f) No CHAB licensee shall allow, permit or suffer any wholesaler to sell, give, dispense, or otherwise transfer or dispose of alcoholic beverages to it unless the wholesaler possesses a valid license from the New Jersey Division of Alcoholic Beverage Council.

SUBCHAPTER 2. CONDUCT OF CHAB LICENSEES

Agency Note: N.J.A.C. 19:50-2.1 is repealed. The full text of this rule is not reproduced herein, but may be found in the New Jersey Administrative Code.

19:50-2.1 Operating conditions of CHAB licensees

CHAB licensees shall comply with N.J.A.C. 33:1-1 et seq., N.J.A.C. 13:2-23 et seq. and all other rulings and bulletins of the Division of Alcoholic Beverage Control regarding the retail sale of alcoholic beverages, except as modified by regulations or rulings of the Commission.

19:50-2.2 Additional operating conditions of CHAB licensees

(a) No employees or agents of a CHAB licensee, except those approved by the Commission, shall consume alcoholic beverages during their hours of employment or agency by a CHAB licensee, including overtime.

(b) No CHAB licensee shall create, expand or decrease in size, close or change the name or type of a CHAB location without notifying the Commission and the Division in writing, as follows:

1. Creation, expansion or decreation in size, or change in type of CHAB authorization: A petition for approval must be submitted at least 10 business days prior to construction or use of the CHAB location, and shall include the name of the location, the floor of the premises where it is located, the type or types of CHAB authorizations, and a floor plan of the location.

2. Permanent closure of a CHAB location: Notification must be filed within five business days after closure.

3. Change in name of a CHAB location: Notification must be filed within five business days after change.

(c) The holder of any CHAB license authorizing the sale of alcoholic beverages for consumption may transfer wine from an original tax paid barrel, cask, keg or other container to another barrel, cask, keg, decanter, bottle or similar container for purposes of interim storage and serve such wine therefrom; provided, however, that each barrel, cask, keg, decanter, bottle or other interim storage container shall have affixed thereto at all times a gummed label clearly identifying the contents thereof; and provided further, however, that nothing herein shall be deemed to prohibit the transfer of wine from original containers or interim storage containers to unlabeled carafes, glasses or similar open receptacles for immediate service to patrons for consumption. The prescribed label shall contain the following information:

This tax paid _____ contains
(type of container)
wine, received from
_____
(type and brand) (name and address
on
_____
of seller) (date of receipt)
_____
(signature)

(d) Combination sales of any kind, consisting of more than one article, whether it be an alcoholic beverage or something else, at a single aggregate price are prohibited, except for:

1. A combination sale consisting of a meal and one alcoholic beverage or a show and one alcoholic beverage, provided that:

i. The alcoholic beverage shall not be advertised as "free," but may be advertised as "included" or "complimentary";

ii. The alcoholic beverage shall be limited to the glass from which the patron will drink, or a bottle of champagne or wine in its original container (not exceeding 187 milliliters (ml.) for one person or 750 ml. for two persons); and

iii. A complimentary non-alcoholic beverage is available and offered as an alternative to the complimentary alcoholic beverage;

2. A combination sale which includes a complimentary bottle of champagne or wine in its original container (not exceeding 187 ml. for one person or 750 ml. for two patrons) as part of a weekend, honeymoon, or other specialty promotional package for hotel guests; or

3. A combination sale consisting of a show and a bottle of champagne in its original container (not exceeding 187 ml. for one person or 750 ml. for two persons) as part of a New Year's Eve promotional package.

(e) No CHAB licensee shall, directly or indirectly, allow, permit or suffer any practice or promotion that:

1. Offers to the public at large unlimited availability of any alcoholic beverage for a set price, except on New Year's Eve;

2. Offers to a patron or consumer a free drink, gift, prize or anything of value, conditioned upon the purchase of an alcoholic beverage or product, except branded or unique glassware or souvenirs in connection with a single purchase; or

3. Requires or allows a consumer to prepurchase more than one drink or product at a time via tickets, tokens, admission fees, two for one, or the like, as a condition for entry into its premises or its authorized location, or as a requirement for service or entertainment therein; provided, however that on New Year's Eve a patron may prepurchase no more than two drinks at a time.

(f) No CHAB licensee shall sell or offer to sell alcoholic beverages at a price below "cost," as defined by the Division of Alcoholic Beverage Control, except that CHAB licensees may serve complimentary alcoholic beverages:

1. In Type I (casino) authorized locations, at a patron's request, pursuant to section 103(g)(1) of the Act;

2. In Type II (hotel), Type III (package goods) or Type IV (room service) authorized locations, pursuant to sections 99 and 102 of the Act and the Commission's rules concerning complimentaries;

3. In conjunction with certain combination sales, pursuant to (d) above; or

4. Using free drink coupons, distributed to the general public pursuant to Bulletin 2452 (1988) of the Division of Alcoholic Beverage Control.

SUBCHAPTER 3. CONDITIONS OF OPERATION IN AUTHORIZED LOCATIONS

19:50-3.1 Conditions of operation in Type I (casino) locations

(a) No alcoholic beverage shall be sold, given or be available for consumption, offered, delivered or otherwise brought to a patron within a casino room unless so requested by the patron.

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

(d) No alcoholic beverage shall be displayed in a Type I location except incidental to delivery or consumption by a patron.

(e) Alcoholic beverages may be served in a Type I location only when the casino room is open for gaming activity as provided in section 97(a) of the Act, but shall not be served later than 15 minutes prior to the closing of the casino room.

19:50-3.2 Conditions of operation in Type II (hotel) locations (Reserved)

19:50-3.3 Conditions of operation in Type III (package goods) locations

(a) No CHAB licensee shall, in a Type III location, sell any alcoholic beverage for delivery to any other area in, on or about the premises.

(b) No CHAB licensee shall, in a Type III location, sell any alcoholic beverage in other than original sealed containers or for consumption within the Type III authorized location.

(c) Sale of alcoholic beverages may include the retail sale of distillers' and vintners' packaged holiday merchandise prepacked as a unit with suitable glassware as gift items to be sold only as a unit, cigars, cigarettes, packaged crackers, chips, nuts and similar snacks, ice and non-alcoholic beverages as accessory beverages to alcoholic beverages and novelty wearing apparel identified with the name or the trade name(s) of the CHAB licensee.

(d) No CHAB licensee shall allow, permit or suffer any alcoholic beverage to be consumed in or upon a Type III location, nor shall any CHAB licensee possess or allow, permit or suffer any open containers of alcoholic beverages in or upon its Type III location; provided, however, that opened bottles of alcoholic beverages returned by a customer as allegedly defective may be so possessed pending return to the manufacturer or wholesaler; and further provided that the container is immediately resealed and labeled with the name and address of the customer and the date of return by the customer.

19:50-3.4 Conditions of operation in Type IV (room service) locations (Reserved)

19:50-3.5 Conditions of operation in Type V (storage) locations

(a) A CHAB licensee may, in a Type V location, store alcoholic beverages intended for sale at other authorized locations in, on, or about the premises.

(b) A CHAB licensee shall transfer or deliver such alcoholic beverages from a Type V location only to authorized locations in, on or about the premises.

(c) A CHAB licensee shall not allow, permit or suffer access to or from a Type V authorized location, except to the extent that such access is necessary in the normal course of business to employees or agents of the CHAB licensee or to licensed employees or agents of wholesalers or distributors licensed pursuant to Title 33 of the Revised Statutes, Title 13 of the New Jersey Administrative Code, the Act and the regulations of the Commission.

(d) All Type V locations shall be fixed, enclosed areas within the premises, not in a casino, and not otherwise authorized for the sale, service or consumption of alcoholic beverages.

(e) No alcoholic beverage shall be sold, served or consumed in a Type V location.

(f) A CHAB licensee shall maintain its Type V locations in a secure manner.

SUBCHAPTER 4. DISCIPLINARY PROCEEDINGS

19:50-4.1 (No change.)

(a)

CASINO CONTROL COMMISSION

Entertainment

Prohibited Entertainment Activities; Entertainment Within the Casino Room

Adopted New Rules: N.J.A.C. 19:52-1.1 and 1.2

Proposed: October 21, 1991 at 23 N.J.R. 3092(a).

Adopted: December 5, 1991 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: December 5, 1991 as R.1992 d.15, **without change.**

Authority: N.J.S.A. 5:12-63(c) and 69(a).

Effective Date: January 6, 1992.

Expiration Date: January 6, 1997.

Summary of Public Comments and Agency Responses:

Comments were received from the Division of Gaming Enforcement (Division), the Casino Association of New Jersey (CANJ) and TropWorld Casino and Entertainment Resort (TropWorld).

COMMENT: TropWorld commented in support of the revised procedures for Commission review of entertainment on the casino floor.

RESPONSE: The Commission agrees, as evidenced by the adoption herein.

COMMENT: The Division suggested a provision to specify that entertainment which is already in progress may be expeditiously terminated in the event that it interferes with casino operations, security or surveillance.

RESPONSE: New rule N.J.A.C. 19:52-1.2(c) provides that the Commission may require immediate cessation of entertainment that in any way compromises the integrity of gaming operations, or which differs in any material manner from the description in the casino licensee's submission.

COMMENT: The Division suggested a new rule to prohibit the possession of weaponry, whether authentic or a facsimile, that may be a threat to any person. The Division also requested that the new rules limit facial makeup so as not to fully obscure the identity of the entertainer, and further, to require a description of any facial makeup used and the purpose thereof.

RESPONSE: New rule N.J.A.C. 19:52-1.2 requires a detailed submission to be filed with both the Commission and Division regarding any entertainment on the casino floor. The Division's comments note various facts and circumstances which may raise legitimate security and surveillance concerns upon review of the requisite submission. Nonetheless, the Commission does not agree that these fact-specific situations can or should be particularized in the new rules.

COMMENT: The Division suggested a new rule to require that each entertainer possess valid identification evidencing his or her membership with the entertainment company.

RESPONSE: Commission rules require that each casino licensee maintain a system for the issuance of "temporary access badges." N.J.A.C. 19:45-1.11(b)7. Any individual entertainer present on the casino floor would thus be identifiable by means of a temporary access badge obtained from the casino licensee's security department.

COMMENT: CANJ argues that the proposed amendments are inappropriate in view of the recent deletion of subsection 70(p) of the Casino Control Act, which mandated that the Commission regulate casino entertainment "in accordance with prevailing community standards".

RESPONSE: The Commission clearly has the duty and authority to promulgate such regulations as it deems necessary in the public interest in carrying out the policies and objectives of the Casino Control Act. N.J.S.A. 5:12-69(a).

COMMENT: CANJ contends that proposed N.J.A.C. 19:52-1.1 unnecessarily codifies prohibitions which already exist in the criminal code.

RESPONSE: Proposed N.J.A.C. 19:52-1.1 sets forth a comprehensive and specific listing of prohibited entertainment practices; no comparable provision exists in the State Criminal Code. For example, N.J.S.A. 2C:14-4 makes lewdness a disorderly persons offense but requires criminal intent to commit the act before nonconsenting persons.

COMMENT: CANJ argues that the casino industry has demonstrated that it can conduct entertainment on the casino floor without interfering with gaming operations.

RESPONSE: The complete elimination of prior review and approval of entertainment on the casino floor is inconsistent with the Commission's duty to ensure the security and integrity of gaming operations.

Full text of the adopted new rules follows.

19:52-1.1 Prohibited entertainment activities

(a) No motion picture shall be exhibited within any casino hotel complex either by direct projection or by closed circuit television which would be classified as obscene material pursuant to the definition contained in N.J.S.A. 2C:34-2.

(b) No live entertainment shall be permitted within a casino hotel complex which includes:

1. The performance of acts, or simulated acts, of sexual intercourse, masturbation, sodomy, bestiality, oral copulation, flagellation or any sexual acts which are prohibited by law;

2. The actual or simulated touching, caressing or fondling of the breasts, buttocks, anus or genitals; or

3. The actual or simulated display of the pubic hair, vulva, genitals, anus, female nipple or female areola.

19:52-1.2 Entertainment within the casino room

(a) No entertainment shall be offered within the the casino room itself, unless the casino licensee receives approval from the Commission to provide such entertainment. The casino licensee shall file a written submission with the Commission and the Division at least five days prior to the commencement of such entertainment, which submission shall include, at a minimum, the following information:

1. The date and time of the scheduled entertainment;

2. A detailed description of the type of entertainment to be offered;

3. The number of persons involved in the entertainment;

4. The exact location of the entertainment on the casino floor;

5. A description of any additional security measures that will be implemented as a result of the entertainment; and

6. A certification from the supervisors of the casino licensee's security and surveillance departments that the proposed entertainment will not adversely affect the security and integrity of gaming operations.

(b) The submission in (a) above shall be deemed approved by the Commission unless the casino is notified in writing to the contrary within three days of filing.

(c) The Commission may at any time after the granting of approval require the licensee to immediately cease any entertainment offered within the casino room if the entertainment provided is in any material manner different from the description contained in the submission filed pursuant to (a) above, or in any way compromises the integrity of gaming operations.

(d) In reviewing the suitability of an entertainment proposal, the Commission shall consider the extent to which the entertainment proposal:

1. May unduly interfere with efficient casino operations;

2. May unduly interfere with the security of the casino room or any of the games therein or any restricted casino area; or

3. May unduly interfere with surveillance operations.

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Route N.J. 57 In Warren County

Adopted Amendment: N.J.A.C. 16:28-1.38

Proposed: October 21, 1991 at 23 N.J.R. 3128(b).

Adopted: November 22, 1991 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: December 4, 1991 as R.1992 d.7, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Effective Date: January 6, 1992.

Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows.

16:28-1.38 Route 57

(a) The rate of speed designated for the certain parts of State highway Route N.J. 57 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic in Warren County:

i.-vi. (No change).

vii. Town of Hackettstown:

(1) Zone 1: 40 miles per hour between the Township of Mansfield easterly line and Route N.J. 182 (approximate mileposts 20.53 to 21.10).

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Stopping and Parking Routes N.J. 7 in Essex County, N.J. 166 in Ocean County; and U.S. 206 in Burlington County
Adopted Amendments: N.J.A.C. 16:28A-1.6, 1.50 and 1.57

Proposed: October 21, 1991 at 23 N.J.R. 3129(a).
Adopted: November 22, 1991 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: December 4, 1991 as R.1992 d.6, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-199.

Effective Date: January 6, 1992.
Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:28A-1.6 Route 7

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

(c) The certain parts of State highway Route 7 described in this subsection shall be designated and established as "no parking" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. No parking bus stops in Belleville Township, Essex County:

i. (No change.)

ii. Along Washington Avenue, northbound on the easterly side thereof at:

(1)-(2) (No change.)

2. No parking bus stops in Nutley Township, Essex County:

i. Along the northbound (easterly) side:

(1) Near side bus stops at:

(A) Hancox Avenue—Beginning at a point 25 feet south of the crosswalk, and extending 95 feet southerly therefrom.

(B) Park Avenue—Beginning at a point 25 feet south of the crosswalk, and extending 95 feet southerly therefrom.

(C) Grant Avenue—Beginning at a point 25 feet south of the crosswalk, and extending 95 feet southerly therefrom.

(D) Rutgers Place—Beginning at a point 25 feet south of the prolongation of the southerly curb line of Rutgers Place, and extending 85 feet southerly therefrom.

(2) Far side bus stops at:

(A) Nutley Avenue—Beginning at a point 35 feet north of the northerly curb line of Nutley Avenue and extending 75 feet northerly therefrom.

(B) Howe Avenue—Beginning at a point 35 feet north of the prolongation of the northerly curb line of Howe Avenue, and extending 75 feet northerly therefrom.

ii. Along the southbound (westerly) side:

(1) Near side bus stops at:

(A) Rutgers Place—Beginning at a point 35 feet north of the northerly curb line of Rutgers Place, and extending 85 feet northerly therefrom.

(B) Park Avenue—Beginning at a point 25 feet north of the crosswalk, and extending 95 feet northerly therefrom.

(2) Far side bus stops at:

(A) Nutley Avenue—Beginning at a point 35 feet south of the southerly curb line of Nutley Avenue, and extending 75 feet southerly therefrom.

(B) Grant Avenue—Beginning at a point 25 feet south of the crosswalk, and extending 85 feet southerly therefrom.

(C) Hancox Avenue—Beginning at a point 35 feet south of the prolongation of the southerly curb line of Hancox Avenue, and extending 75 feet southerly therefrom.

(D) Howe Avenue—Beginning at a point 35 feet south of the southerly curb line of Howe Avenue, and extending 75 feet southerly therefrom.

16:28A-1.50 Route 166

(a) The certain parts of State highway Route N.J. 166 described in this subsection are designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times.

1.-2. (No change.)

(b) The certain parts of State highway Route N.J. 166 described in this subsection shall be designated and established as "no parking" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1. Along the southbound (westerly) side in Dover Township, Ocean County:

i. Mid-block bus stops at:

(1) Presidential Boulevard—From a point 275 feet north of the northerly curb line of Presidential Boulevard to a point 410 feet north of the northerly curb line of Presidential Boulevard.

(2) Route 37—From a point 180 feet south of the southerly curb line of Route 37 to a point 315 feet south of the southerly curb line of Route 37.

(3) South Dakota Avenue—Beginning at a point 100 feet south of the southerly curb line of South Dakota Avenue and extending 135 feet southerly therefrom.

ii. Far side bus stops at:

(1) Broad Street—From the southerly curb line of Broad Street to a point 100 feet southerly therefrom.

(2) Colonial Road—Beginning at the prolongation of the southerly curb line of Colonial Road and extending 100 feet southerly therefrom.

iii. Near side bus stop at:

(1) Winteringham Village—Beginning 15 feet north of the northerly curb line of Winteringham Village and extending 140 feet northerly therefrom.

2. Along the northbound (easterly) side in Dover Township, Ocean County:

i. Near side bus stops at:

(1) James Street—Beginning 50 feet south of the southerly curb line of James Street and extending 125 feet southerly therefrom.

(2) South Dakota Avenue—Beginning at the prolongation of the southerly curb line of South Dakota Avenue and extending 105 feet southerly therefrom.

ii. Far side bus stops at:

(1) Dover Street—From the northerly curb line of Dover Street to a point 100 feet north thereof.

(2) Fernwood Drive—From the northerly curb line of Fernwood Drive to a point 120 feet north thereof.

iii. Mid-block bus stops at:

(1) Route 37—From a point 155 feet south of the southerly curb line of Route 37 to a point 265 feet south of the southerly curb line of Route 37.

(2) James Street—From a point 70 feet south of the southerly curb line of James Street to a point 145 feet south of the southerly curb line of James Street.

(c) The certain parts of State highway Route N.J. 166 described in this subsection are designated and established as "no parking" zones.

1. (No change.)

16:28A-1.57 Route U.S. 206

(a) (No change.)

(b) The certain parts of State highway Route U.S. 206 described in this subsection shall be designated and established as "no parking" zones where parking is prohibited at all times. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established bus stops:

1.-11. (No change.)
12. Along the southbound (westerly) side in Bordentown Township, Burlington County:
i.-ii. (No change.)
iii. Near side bus stops at:
(1)-(2) (No change.)
(3) Park Street—Beginning 45 feet north of the northerly curb line of Park Street and extending 105 feet northerly therefrom.
(c) (No change.)

(a)

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

No Passing Zones
Routes N.J. 50 in Atlantic City, N.J. 41 in Gloucester County; and N.J. 143 in Camden County
Adopted Amendment: N.J.A.C. 16:29-1.70
Adopted New Rules: N.J.A.C. 16:29-1.71 and 1.72

Proposed: October 21, 1991 at 23 N.J.R. 3130(a).
Adopted: November 22, 1991 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: December 4, 1991 as R.1992 d.8, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-201.1.

Effective Date: January 6, 1992.
Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:29-1.70 Route 50
(a) The following certain parts of State highway Route 50 shall be designated and established as "No Passing" zones:
1. (No change.)
2. That part within the Cities of Corbin City, Estelle Manor and Egg Harbor and the Townships of Weymouth, Hamilton and Galloway, Atlantic County, as described in drawing #HNPZ-119, dated May 9, 1991.

16:29-1.71 Route 41
(a) The following certain parts of State highway Route N.J. 41 shall be designated and established as "No Passing" zones:
1. That part within the Township of Deptford, Gloucester County, as described in drawing #HNPZ-116, dated May 9, 1991.

16:29-1.72 Route 143
(a) The following certain parts of State highway Route N.J. 143 shall be designated and established as "No Passing" zones:
1. That part within the Township of Winslow, Camden County, as described in drawing #HNPZ-118, dated May 9, 1991.

(b)

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

Miscellaneous Traffic Rules
Drawbridge Usage
Routes N.J. 37 in Ocean County
Adopted Amendment: N.J.A.C. 16:30-9.10

Proposed: October 21, 1991 at 23 N.J.R. 3131(a).
Adopted: November 22, 1991 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: December 4, 1991 as R.1992 d.9, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 27:7-17.

Effective Date: January 6, 1992.
Expiration Date: June 1, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows.

16:30-9.10 Route 37
(a) The certain parts of State highway Route 37 described in this subsection shall have pedestrian restrictions for the purposes described. In accordance with N.J.S.A. 39:4-198, authority is granted to erect appropriate signs.
1. (No change.)
2. Pedestrians shall be prohibited from walking along both sides of the entire length of the Thomas A. Mathis Bridge over Barnegat Bay in Dover Township, Ocean County.
3. Pedestrians shall be prohibited from walking along the south side of the entire length of the J. Stanley Tunney Bridge over Barnegat Bay in Dover Township, Ocean County.

(c)

DIVISION OF PROCUREMENT
BUREAU OF CONSTRUCTION SERVICES PROCUREMENT

Classification of Prospective Bidders
Statements under Oath, Penalties for False Statements, Types of Work; Classification Rating System; Determination of Rating for Contractors with Verifiable Work Experience; Determination of Rating for Newly Formed Contractors; Renewal of Classification Ratings; Bidding; Exclusion of Bids; Certification of Current Bid Capacity; Bidding By Out-of-State Corporations; Rejection of Bids; Information to Accompany Bids; Joint Ventures; Appeals and Enforcement
Adopted Amendment: N.J.A.C. 16:44-1.1
Adopted Repeal and New Rule: N.J.A.C. 16:44-1.2
Adopted New Rules: N.J.A.C. 16:44-1.3 through 1.16

Proposed: November 4, 1991 at 23 N.J.R. 3270(a).
Adopted: December 10, 1991, by George Warrington, Deputy Commissioner, Department of Transportation.
Filed: December 13, 1991 as R.1992 d.29, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 27:7-2.1 and 27:7-35.2 et seq.

Effective Date: January 6, 1992.
Expiration Date: May 25, 1993.

Summary of Public Comments and Agency Responses:

Comments were received from Mr. Robert A. Briant Sr., Executive Director, Utility and Transportation Contractors Association of New Jersey, Lakewood, New Jersey.

COMMENT: N.J.A.C. 16:44-1.2(a)5.1 requires that the work record also disclose "labor troubles experienced."

We certainly understand that information of this type can be of value to the Department. However, how does one define labor troubles experienced? Does such data include jurisdictional disputes between union laborers and ironworkers regarding the movement of precast barrier? Does such data include a dispute because a steward has been discharged and a replacement steward requested from the union?

As proposed, some contractors might classify these matters as labor troubles, while others might not. The Department should consider defining what is meant by the phrase "labor troubles experienced."

RESPONSE: The rules allow or state that "the contractor shall explain all such items." If they experience labor problems of any type, the Department should be aware of them. The Department does give them a chance to explain the problem and, if the Department feels it is necessary, it may investigate further. It is not felt that any further explanation is needed.

COMMENT: N.J.A.C. 16:44-1.13(b)4i notes that if a contractor is bidding several projects in one day and reserves the right to only accept a certain amount of awards, the Commissioner will have the right to select which contract or contracts to award to the contractor.

We believe that the contractor should have the right to select which contract to take. The contractor is taking the risk with his/her competitive bid and that risk should not be finally determined by anyone else.

This concern can also be handled administratively. We have suggested for some time that bids should not be taken at the same time, if there are multiple bids in one day.

RESPONSE: In order to insure the integrity of the competitive bidding process, and to protect the public interest, the Commissioner must retain the right to make the final decision regarding a contract. The Department will entertain specific requests of contractors, whenever possible. The policy of expediting contract awards due to the current economic situation has made the handling of mulitple bids in one day a necessity.

COMMENT: N.J.A.C. 16:44-1.8(c)2 provides for a hearing, if the contractor is denied a classification or assigned a limited project rating.

If the denial is based on the contractor's performance rating, the results of which are not available to the contractor, the hearing might be too late for the contractor to bid a specific project. We believe strongly that the contractor "average past performance rating" and how it is calculated be made available to each contractor. Such data is subjective and if it has any bearing on the contractor final rating, should be made available to the contractor.

RESPONSE: All contractors who have a Performance Rating on file will be notified of that rating with his Notice of Classification.

Full text of the adoption follows.

SUBCHAPTER 1. CLASSIFICATION OF CONTRACTORS AND PROSPECTIVE BIDDERS

16:44-1.1 Definitions

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

"Aggregate Rating" means the dollar limit of contract work that a contractor will be allowed to have outstanding at any given time, and includes the dollar value of all work in progress.

...

"Current Bid Capacity" means the lesser of a contractor's Project Rating or Maximum Rating.

...

"Maximum Rating" means the dollar figure established by subtracting the contractor's current dollar amont of outstanding work from its Aggregate Rating.

...

"Project Rating" means the dollar limit which a contractor shall be allowed to bid on an individual project.

...

16:44-1.2 Statements under oath

(a) All contractors proposing to bid on Department of Transportation work must furnish, on forms provided by the Commissioner of Transportation, a Prequalification Questionnaire including, at a minimum, the following statements:

1. A statement as to financial ability, which statement shall show current assets and current liabilities and shall include verifications of unsecured lines of credit extended by banks. The Prequalification Questionnaire must be accompanied by certified audited financial statements or a CPA review of financial statements. The financial statements must be complete with a balance sheet, related statements of income and retained earnings and cash flows. They must be completed by a certified public accountant or public accountant, as established by N.J.S.A. 45:2B-29 et seq., who is independent of and not an employee of the contractor for which the financial statements are being provided;

i. The certified audited financial statements should have an unqualified opinion. The CPA review of financial statements shall be in conformity with generally accepted accounting principles. Both the audited and CPA review financial statements shall be for a full one year accounting cycle;

ii. Submission of a CPA review of financial statements will limit the contractor's maximum project rating to $2,000,000. In addition, the aggregate rating will be limited to the total uncompleted work on hand at the time of the classification, plus $2,000,000;

iii. Submission of a consolidated financial statement is acceptable. It may be submitted with the Prequalification Questionnaire completed in the name of the parent corporation;

2. A statement as to plant and equipment, which shall give complete details as to cost, age, condition and book value and outstanding loans;

3. A statement as to organization, which shall show the ability of such organization, including key personnel, to undertake a project in the classification desired;

4. A statement as to prior experience, which shall show the length of time in which the contractor has been engaged in the contracting business. It shall also disclose the nature of the contractor's experience during that period;

5. A statement which shall give an accurate and complete record of work completed in the three prior years and which shall identify the projects undertaken, type of work performed, location, contract price, name and telephone number of the owner's engineer in charge;

i. The work record statement shall list, in detail, any liens, stop notices, default notices or claims filed with regard to any project within the previous three years. The work record statement shall also disclose labor troubles experienced, failures to complete contracts and all penalties imposed by reason of any contract undertaken within the previous three years. The contractor shall explain all such items;

ii. Any contractor which has been continuously qualified with the Department of Transportation for a period of four years shall not be required to complete this statement, unless the statement contractor desires to be classified for a different type of work than that for which it has previously been classified;

6. A statement setting forth any other pertinent and material facts which will justify the classification and rating desired;

7. A statement that the contractor has adopted an Affirmative Action Program for Equal Employment Opportunity in accordance with State and Federal laws, rules and regulations;

8. If the contractor is a corporation or partnership, a statement setting forth the names and addresses of all stockholders or partners owning 10 percent or greater interest in the contractor. If one or more stockholders or partners is, itself, a corporation or partnership, the statement shall also indicate the stockholders holding 10 percent or more of that corporation's stock or the individual partners owning a 10 percent or greater interest in that partnership. The disclosure shall be continued until the names and addresses of every non-corporate stockholder or partner exceeding the 10 percent ownership criterion has been listed;

9. A prequalification affidavit attesting that all statements conatined in the Prequalification Questionnaire are true and accurate; and

10. A statement identifying the types of work for which the contractor is seeking classification.

16:44-1.3 Penalties for false statements

(a) Any person who makes, or causes to be made, a false, deceptive or fraudulent statement in the Prequalification Questionnaire required to be submitted, or in the course of any hearing pertaining to an application for prequalification, shall be guilty of a misdemeanor, and upon conviction shall be sentenced to pay a fine of not less than $100.00, nor more than $1,000; or in the case of an individual or the officer or employee charged with the duty of making such questionnaire for a person, firm, copartnership, association or corporation, to pay such fine or undergo imprisonment, not to exceed six months, or both.

(b) All such persons and any copartnership, association, corporation, or joint stock company of which any such person is a partner or officer or director, and any corporation of which such person owns 25 percent of the stock, shall, for five years from the date of such conviction, be disqualified from bidding on all public work in this State.

(c) As used in this rule, "person" means and includes any individual copartnership association, corporation or joint stock company their lessees, trustees, assignees or receivers appointed by any court whatsoever.

16:44-1.4 Types of work

(a) Contractors will be classified according to the type of work and the amount of work on which they may bid.

(b) The types of work for which contractors may seek classification are on file at the Department of Transportation, Bureau of Construction Services, 1035 Parkway Avenue, CN 605, Trenton, New Jersey 08625.

(c) Each contractor will be classified for one or more types of work and will be rated in accordance with its financial ability, adequacy of plant and equipment, organization, record of construction and any other factors deemed pertinent by the Department of Transportation. The contractor will be assigned a classification, designating the types and dollar values of work upon which it shall be eligible to bid.

(d) The Commissioner of Transportation will notify a contractor of its classification by first class mail within 15 days of the Department's receipt of a complete Prequalification Questionnaire. If the Department requests from the contractor additional information needed to complete the Prequalification Questionnaire submitted or to clarify information contained in the Prequalification Questionnaire, the contractor will be notified of its classification by first class mail within 15 days of the Department's receipt of the specified information. Any contractor which fails to submit a complete Prequalification Questionnaire, as determined by the Department, will be denied classification.

(e) The dollar rating ranges within which contractors may be entitled to bid are as set forth in Table I below.

TABLE I
DOLLAR RATING RANGES

$ 50,001 to 100,000	20,000,001 to 25,000,000
100,001 to 150,000	25,000,001 to 30,000,000
150,001 to 200,000	30,000,001 to 35,000,000
200,001 to 300,000	35,000,001 to 40,000,000
300,001 to 400,000	40,000,001 to 45,000,000
400,001 to 500,000	45,000,001 to 50,000,000
500,001 to 750,000	50,000,001 to 55,000,000
750,001 to 1,000,000	55,000,001 to 60,000,000
1,000,001 to 2,000,000	60,000,001 to 65,000,000
2,000,001 to 3,000,000	65,000,001 to 70,000,000
3,000,001 to 4,000,000	70,000,001 to 75,000,000
4,000,001 to 6,000,000	75,000,001 to 80,000,000
6,000,001 to 8,000,000	80,000,001 to 85,000,000
8,000,001 to 10,000,000	85,000,001 to 90,000,000
10,000,001 to 15,000,000	95,000,001 to 99,999,999
15,000,001 to 20,000,000	over 99,999,999

1. A contractor whose statements do not qualify the contractor to bid an amount in the $50,001 to $100,000 range will be classified with an Aggregate Rating equal to its calculated capacity.

2. A contractor, qualified to bid in excess of $99,999,999, will be notified when the Department of Transportation intends to put out for bid a project in the "Unlimited" class. Each such contractor that desires to bid the "Unlimited" class project shall be required to specifically prequalify to bid upon that project. The contractor must apply for such specific classification at least 20 days before the date set for the receipt of bids on the "Unlimited" class project.

16:44-1.5 Classification rating system

(a) Each contractor will be assigned both an Aggregate Rating and a Project Rating. The dollar limits of these ratings will be related to the work type classifications for which the contractor, its officers and key personnel have demonstrated sufficient experience of acceptable quality to be granted a rating.

(b) Aggregate Ratings will be established as follows:

1. The Aggregate Rating will be based on the contractor's net working capital. Net working capital is represented by the excess of current assets over current liabilities and identifies the relatively liquid portion of total enterprise capital which constitutes a margin for meeting obligations within the ordinary operating cycle of the business. A contractor's net working capital can be supplemented by unsecured lines of credit and the net book value of construction equipment. The contractor's allowed assets will be multiplied in accordance with (b)3 below.

2. The Department of Transportation reserves the right to use the contractor's net worth, as shown in the balance sheets, as the basis of the firm's net working capital when review and analysis of the financial transactions undertaken by the contractor so require.

3. The Department of Transportation will add dollar figures established by use of the multipliers indicated below. For contractors which have not had a Department of Transportation performance rating within the prior four year period, the resulting figure shall be the contractor's aggregate rated capacity. For contractors which have had a Department of Transportation performance rating within the prior four year period, the resulting figure will be multiplied by the contractor's average performance rating percentage to establish the contractor's aggregate rated capacity.

Contractors without NJDOT past performance

Aggregate rated capacity = (Net working capital × 9) + (net book value of equipment × 9) + (unsecured lines of credit × 4).

Contractors with NJDOT past performance

Aggregate rated capacity = (net working capital × 15) + (net book value of equipment × 15) + (unsecured lines of credit × 7) × average past performance rating.

4. A contractor's aggregate rated capacity will be reduced by 15 percent if it neither owns nor leases, on a continuing basis, the equipment necessary to perform the work within its work category.

5. A contractor's Aggregate Rating will be established by application of its aggregate rated capacity to Table I at N.J.A.C. 16:44-1.4(e).

6. A contractor will not be permitted to bid beyond its aggregate rating.

(c) Project Ratings, based on an evaluation of contractor's verifiable work experience and the experience profile of its officers and other key personnel, will be established as follows:

1. When a contractor has performed work for the Department of Transportation and received a performance rating within the previous four years, its Project Rating will be based on its performance rating, as applied in N.J.A.C. 16:44-1.8, for the classification work types associated with the performance rating.

2. When a contractor has never been classified by the Department of Transportation or when a contractor has not received a performance rating from the Department within the previous four years, past work experience and experience of officers and key personnel will be evaluated through the use of work experience verification letters and/or personal contacts. Recently formed contractors, with limited or no work history will be evaluated by the use of detailed individual experience profiles.

16:44-1.6 Determination of Project Rating for contractors with verifiable work experience, but no Department of Transportation past performance rating

(a) In order to evaluate the work experience of a contractor, the Department of Transportation will obtain information from public and private owners for whom the contractor has performed work. The information will be reviewed and evaluated in the manner set forth in Table II, Quality Points, below.

TABLE II
QUALITY POINTS

Rating	Excellent	Good	Fair	Poor
QUALITY OF WORK (Grading, Paving, Bridge, etc.)	1.00	0.80	0.50	0
COMPLETION OF WORK PER REQUIRED SCHEDULE	0.50	0.40	0.25	0
SUPERVISION	USED FOR GENERAL INFORMATION			
ADEQUACY OF EQUIPMENT	USED FOR GENERAL INFORMATION			

SUPPLEMENTAL QUALITY POINTS
(Only A or B Applies)

A. For work experience determined to be equivalent to NJDOT work (Equivalent work is deemed to be work for other DOT's, U.S. Army Corps of Engineers, New Jersey Turnpike Authority, New Jersey Highway Authority, etc.): 1.00

B. For work experience determined to be similar to NJDOT work (similar work is deemed to be work for County, City, Township, Municipal, or Utility Authorities): 0.50

(b) The average, to the nearest 0.1 point, of the quality points calculated for each individual work evaluation will be multiplied by the dollar value of the largest successfully completed project for which an evaluation was performed and in which the contractor engaged in the work types for which classification is being sought. A contractor's Project Rating will be established by locating the resulting dollar figure on Table I at N.J.A.C. 16:44-1.4(e).

(c) If the contractor's major work program is evaluated to be equivalent in scope and expertise level to that of NJDOT projects and work quality is evaluated to be good or excellent, the contractor's Project Rating will be set equal to its Aggregate Rating, up to $99,999,999.

(d) In no event shall a contractor's Project Rating be allowed to exceed its Aggregate Rating.

16:44-1.7 Determination of Project Rating for newly formed contractors

(a) A contractor without any verifiable past contracting work experience or a contractor with limited or no work experience of the type required for the classification being sought will be evaluated on the basis of detailed individual experience resumes. Officers and key personnel must submit individual experience resumes detailing those experiences applicable to the work type classifications for which the contractor is applying.

(b) Upon verification of acceptable work experience, the Department of Transportation will grant a Project Rating corresponding to the level and quality of past experience demonstrated by the officers and key personnel of the contractor. If the key personnel to be evaluated are not officers or stockholders of the contractor, the contractor shall submit an affidavit, stating that these individuals are currently full-time employees of the contractor and that the contractor will immediately notify the NJDOT of any change in their employment status. Upon notification of a change in the employment of key personnel, the NJDOT may reevaluate the contractor's classification.

(c) In no event shall a contractor's Project Rating be allowed to exceed its Aggregate Rating.

16:44-1.8 Renewal of classification ratings

(a) Upon renewal of classification, a contractor's Aggregate Rating will be established in accordance with the procedure set forth in N.J.A.C. 16:44-1.5.

(b) Upon renewal of classification, contractors without a NJDOT past performance rating within the previous four years will be evaluated on the basis of the information and in accordance with the procedures described in N.J.A.C. 16:44-1.6 and/or 1.7.

(c) Upon renewal of classification, contractors with a NJDOT past performance rating within the previous four years will be evaluated on the basis of their average performance rating and a Project Rating will be established in the following manner:

1. If a contractor's average performance rating is five points or more below the average performance rating of all contractors that have received a NJDOT performance rating within the previous four years, the contractor's average past performance percentage will be multiplied by a dollar level equal to three times the largest successfully completed NJDOT or equivalent contract performed during the prior four years. The contractor's Project Rating will be determined by applying the resulting dollar figure to Table I at N.J.A.C. 16:44-1.4(e).

2. If a contractor's average performance rating is 15 points or more below the average performance rating of all contractors that have received a NJDOT performance rating within the previous four years, the Department of Transportation may, in the public interest, determine to deny the contractor classification or assign a limited Project Rating instead of assigning a Project Rating pursuant to N.J.A.C. 16:44-1.8. If denied classification or assigned a limited project rating, the contractor will be accorded a hearing pursuant to N.J.A.C. 16:44-1.16.

3. If the two most recent performance ratings assigned a contractor during the prior four year period average five points or more above the average performance rating of all contractors that have received a NJDOT performance rating within the previous four years, the contractor will be entitled to a Project Rating equal to its Aggregate Rating, up to a limit of OVER $99,999,999.

4. If the four most recent performance ratings assigned a contractor during the prior four years are at least equal to the average performance rating of all contractors that have received NJDOT performance rating within the previous four years, the contractor will be entitled to a Project Rating equal to its Aggregate Rating, up to a limit of OVER $99,999,999.

16:44-1.9 Bidding

(a) Any contractor assigned a classification by the Department of Transportation may submit a bid proposal on any project within its classification for a period of 18 months from the date of the close of business shown in its Prequalification Questionnaire. However, no bid will be received from any contractor on any given date unless a complete Prequalification Questionnaire showing a close of business date less than 18 months before the bid date has been filed with the Department at least fifteen days before such bid date.

(b) Contractors shall submit a Prequalification Questionnaire as required by N.J.A.C. 16:44-1.2 or this section, or on such other intermediate occasions as may be deemed necessary by the Commissioner of Transportation.

16:44-1.10 Exclusion of bids

(a) Bids will be accepted only from a contractor which has been assigned a classification by the Department of Transportation. In no event will a bid be accepted from a contractor which is not currently classified or for work different in type or greater in amount than that to which the contractor's classification applies.

(b) When there exists a doubt as to whether a bid is within the classification for which the contractor is qualified the bid will be opened provisionally and if the bid is, in fact, within a higher classification than that for which the prospective bidder is classified, the bid will be immediately excluded.

(c) Bids will be accepted only if an authorized agent, employee or officer of the contractor has acknowledged receipt of all applicable addenda.

16:44-1.11 Certification of current bid capacity

(a) A contractor submitting a bid proposal to the Department of Transportation must compute and certify its current bid capacity on a Form DC-74B, Contractor's Updated Financial Statement. A contractor's bid shall not be considered responsive if it does not include the required computation and certification.

(b) A contractor's Current Bid Capacity is the lesser of the contractor's Project Rating or its Maximum Rating. The contractor's Maximum Rating is the dollar figure established by subtracting the contractor's current dollar amount of outstanding work from its Aggregate Rating.

(c) In the event that a contractor submits bid proposals on two or more Department of Transportation projects on the same date and is apparent low bidder on more than one project, the contractor must have current bid capacity greater than or equal to the combined amount of its successful bids. An unsecured line of credit, in addition to any unsecured line of credit provided at the time of prequalification, may be submitted with the contractor's bids and added into the computation of Current Bid Capacity.

(d) A contractor shall not bid more than its current bid capacity. Any bid in excess of the current bid capacity will be excluded.

16:44-1.12 Bidding by out-of-State corporations

(a) In the event a corporation not incorporated in the State of New Jersey is the lowest bidder on a project, it must be authorized to do business in New Jersey, pursuant to N.J.S.A. 14A:15-1 et seq., before the contract will be executed by the Commissioner of Transportation.

(b) Each corporation, partnership or individual residing in a state other than New Jersey shall designate a resident of New Jersey to accept service of any legal process before the Commissioner of Transportation will execute a contract with such corporation, partnership or individual.

16:44-1.13 Rejection of bids

(a) The Commissioner of Transportation may disqualify any contractor and reject its bid at any time prior to the actual award of a contract where there have been developments subsequent to qualification and classification which, in the opinion of the Commissioner, would affect the responsibility of the bidder. Before taking such action, the Commissioner will notify the bidder and give it an opportunity to present additional information in support of its responsibility.

(b) Proposals may be rejected for the following reasons:

1. If the proposal is on a form other than that furnished by the Department; or if the form is altered or any part thereof is detached or incomplete;

2. If the proposal is not properly signed;

3. If there are unathorized additions, conditional or alternate bids, or irregularities of any kind which may tend to make the proposal incomplete, indefinite, or ambiguous as to its meaning;

4. If the bidder adds any provisions reserving the right to accept or reject an award, or to enter into a contract pursuant to an award;

i. The only exception permitted shall be a reservation limiting the maximum gross amount of awards acceptable to any one bidder at any one bid letting. However, the Commissioner will make the selection of which contract or contracts are to be awarded to such bidder within the maximum gross amount reserved;

5. If the bidder makes an alteration of the "Unit Prices" or "Amounts" that have been included by the Department, unless otherwise directed by Addendum received prior to receipt of bids;

6. If the proposal is not accompanied by an acceptable updated financial statement (Form DC-74B); or

7. If the Commissioner deems it advisable to do so in the interest of the State.

(c) Pursuant to N.J.S.A. 27:7-7.32, a proposal shall be rejected if it is not accompanied by a satisfactory Proposal Bond.

16:44-1.14 Information to accompany bid

(a) In order that the Commissioner of Transportation may have the information necessary to pass upon the ability of a bidder to satisfactorily complete a project, each contractor must submit with its bid on each proposal the status of contracts on hand as of the date specified in the Notice of Contractors, a certification of Current Bid Capacity and the proposal affidavit.

(b) Updated financial statements (Form DC-74B) submitted with bids originally advertised for receipt of bids between the 1st and 15th of the month must include information accurate as of the close of business at the end of the second month preceding that during which bids are being received.

(c) Updated financial statements (Form DC-74B) submitted with bids originally advertised for receipt of bids between the 16th and the end of the month must include information accurate as of the close of business at the end of the month preceding that during which bids are being received.

(d) A contractor may submit with its bid a new unsecured line of credit, in addition to the available unsecured line of credit submitted at the time of classification, in order to maintain a current bid capacity sufficient to cover the total amount bid.

16:44-1.15 Joint ventures

Two or three contractors holding valid classifications from the Department of Transportation may file a request to form a joint venture for the purpose of submitting a bid proposal on a specific project. A Joint Venture Statement must be filed with the Bureau of Construction Services at least five days prior to the date set for the receipt of bids on the project.

16:44-1.16 Appeals and enforcement

(a) A contractor dissatisfied with its classification may request a hearing before the Prequalification Committee and at the hearing may present further evidence to justify a different classification. A change in classification will only be effective for an advertised project if the contractor has provided to the Prequalification Committee all information necessary to support the change request at least 15 days prior to the date on which bids are received.

(b) Except where specifically and expressly permitted, no deviation from this subchapter will be allowed.

Recodify 16:44-1.3 through 1.7 as 1.17 through 1.21 (No change in text.)

HEALTH

(a)

HEALTH FACILITIES EVALUATION AND LICENSING

Manual of Standards for Licensure of Invalid Coach and Ambulance Services

Readoption with Amendments: N.J.A.C. 8:40

Proposed: September 3, 1991 at 23 N.J.R. 2566(a).

Adopted: November 25, 1991 by Frances J. Dunston, M.D., M.P.H., Commissioner, Department of Health (with approval of the Health Care Administration Board).

Filed: December 6, 1991 as R.1992 d.16, **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. 26:2H-1 et seq. and 30:4D-6.2 et seq., specifically 30:4D-6.3 and 4.

Effective Date: December 6, 1991, Readoption
January 6, 1992, Amendments
Expiration Date: December 6, 1996.

Summary of Public Comments and Agency Responses:

The Department received 18 letters (13 of which were from licensed Invalid Coach and Ambulance providers) containing comments on the rules proposed for readoption during the comment period which closed on October 3, 1991. The licensed providers were: Able Ambulance & Invalid Coach Service, Inc.; American Medi Wheels/Vanguard; An Mar Ambulance, Inc.; Eagle Ambulance and Medi Coach; Eagle Medical Transport; Healthtec; Invalid Coach Service of New Jersey; Life Support Ambulance, Inc.; Martin's Ambulance; On Time Transport, Inc.; SAS Ambulance; Transportation Care; and the University of Medicine and Dentistry of New Jersey. Other commenters included the Medical Transportation Association of New Jersey; the State Division on Aging; County of Bergen, Office of Special Transportation; Dial, Inc.; Christian Science Committee on Publication for the State of New Jersey; and Wickham Associates, Inc. Two of the commenters, American Medi Wheels/Vanguard and Eagle Ambulance, said that they wished the comments of the Medical Transportation Association of New Jersey to be considered their own. They have been included under each specific comment below. All of these letters are on file at the New Jersey Department of Health, Office of Emergency Medical Services.

On the basis of the comments and recommendations received, the Department has made several changes to the proposed rules. These changes serve to clarify Department intent, improve ambulance patient care, allow for safer and more comfortable transport of wheelchair-bound patients, and provide a safer working environment for the provider's staff.

The following is a summary of the comments submitted in reference to the proposed rules and the corresponding Department responses.

COMMENT: Four of the commenters applauded the Department for the general changes proposed to the rules.

RESPONSE: The Department appreciates the commenters' recognition.

COMMENT: Two commenters, the State Division on Aging and Dial, Inc., recommended that the Department use a term other than "invalid coach." They were concerned about the connotation implied in this "outdated terminology."

RESPONSE: The Department is unable to change the term at this time. The service is called "Invalid Coach" in the enabling legislation (N.J.S.A. 30:4D-6.2 et seq.).

COMMENT: The Christian Science Committee on Publication for the State of New Jersey suggested that the definitions for health care facilities and caregivers listed in various sections of the rules specifically mention Christian Science practitioners and Christian Science nursing facilities.

RESPONSE: The Department has broadened the definitions of "Invalid Coach Service" in N.J.A.C. 8:40-1.1, and the "patient restrictions" paragraphs in N.J.A.C. 8:40-4.1(a), 5.2(a) and 6.1(a), to include "other recognized healthcare provider." These changes are equitable to all other forms of recognized care. The effect of this change is to allow individuals to be transported for a fee to Christian Science or other healthcare provider recognized by the Department. It is not the Department's intent, with this change, to enlarge the scope of the rules to include the regulation of those forms of transportation which are not billed on a fee-for-service basis to either private, Medicaid/Medicare or a third party insurer.

COMMENT: Six commenters suggested that the required size of the trade name lettering be kept at three inches, rather than changed to the six inches which had been proposed. Some of the commenters explained that their trade names would not fit on the side of their vehicles, if required to be in six-inch letters. One additional provider agreed with the change to six inches, but suggested that the Department add a provision to grandfather the size of lettering on all current vehicles.

RESPONSE: Past experience has shown that three-inch high trade names are too small for the public or enforcement personnel to easily read, when the vehicle is traveling on the road. Citizen complaints about misuse of lights and siren, hit and run accidents, and other poor driving practices have been difficult or impossible to investigate, when they are made without a provider trade name. However, the Department agrees that services with long trade names may have difficulty fitting the name onto their vehicles, using six-inch letters. Therefore, the Department has changed subsections N.J.A.C 8:40-4.5(a), 5.7(a), and 6.7(a), the appropriate subsections in the Invalid Coach Transport Ambulance, and Emergency Ambulance rules respectively, to require trade name lettering to be a minimum of four inches high, when vehicles are licensed for the first time after March 1, 1992.

COMMENT: Six commenters suggested that the Department delete the words, "approved by the Department," from subsections N.J.A.C 8:40-4.14(a), 5.25(a) and 6.29(a), Call report, the appropriate paragraphs in the Invalid Coach, Transport Ambulance, and Emergency Ambulance rules respectively.

RESPONSE: These words were only added as clarification. The Department has always approved providers' call reports prior to their use. The current rules require that specific information be collected on the call report form. This information is necessary in order to investigate patients' complaints and to document the care given. The Department declines to make this change.

SUBCHAPTER 1. DEFINITIONS

COMMENT: Eight commenters suggested that the definition of "advanced life support" incorrectly included the word "interhospital." The commenters wished to limit the definition to cover only prehospital services.

RESPONSE: The definition, except for noting the applicable law and regulation, is a direct quote from the "Paramedic Law," N.J.S.A. 26:2K-7 et seq. The Department declines to change it.

COMMENT: Four commenters suggested that the term "crashworthy" be defined.

RESPONSE: A defnition has been added.

COMMENT: Five commenters suggested that the term "emergency" be defined.

RESPONSE: A definition has been added.

COMMENT: One commenter questioned what the term "payment for services" meant in the definition of "volunteer first aid, rescue or ambulance squad."

RESPONSE: The definition for "payment for services" is already listed separately. No change is needed.

SUBCHAPTER 2. AUTHORITY AND LICENSURE PROCEDURES

N.J.A.C. 8:40-2.3(a) Certificate of need required

COMMENT: One commenter objected to the requirement for Certificate of Need approval.

RESPONSE: Under N.J.S.A. 26:2H-7, Certificate of Need approval is required before a service can apply for a license to operate.

N.J.A.C. 8:40-2.3(c) Certificate of Need required

COMMENT: Seven commenters questioned the need for 90-day prior notice to the Department in order to discontinue providing emergency ambulance services (street EMS). Two providers suggested that it could, in effect, force service to be provided without pay past the contract term with a municipality. Municipal contracts generally have a 30-day cancellation clause.

RESPONSE: N.J.A.C. 8:33-2.6(a)2 requires a 60-day notice to the Department prior to discontinuation of a licensed health care service. The notification requirement in N.J.A.C. 8:40-2.3(c) has been changed to 60 days to agree with that requirement. While service could, theoretically, be required without pay, Department experience has shown no instances of such situations.

N.J.A.C. 8:40-2.4(i) Licensing requirements

COMMENT: Three commenters suggested that the 45-day conditional permits should be issued at the discretion of the Chief Administrator, Emergency Medical Services and not by the "authorized representative" to protect the integrity of the rules.

RESPONSE: Nothing in the paragraph precludes the Chief Administrator, Emergency Medical Services from reviewing the provider and/or vehicle survey, when necessary. The Department declines to change the requirement, since the Chief Administrator, like a Commissioner, must be able to delegate work in order to accomplish the goals of the Department.

N.J.A.C. 8:40-2.5(a) Exemptions from licensing requirements

COMMENT: Three commenters wanted the rules expanded to cover all invalid coach and ambulance patient transport services in New Jersey. Specifically, they wanted the Department to remove the exemptions from licensure for volunteer first aid and ambulance services. One commenter

also suggested that "exempt" invalid coach services, provided by agencies which get Medicaid monies in ways other than direct billing (for example, county social service transport agencies), should be regulated.

RESPONSE: The Department only has jurisdiction to regulate the services defined in the enabling legislation (N.J.S.A 30:4D-6.2 et seq. and N.J.S.A. 26:2H-1 et seq.). Further, volunteer ambulance services, as defined in N.J.S.A. 27:5F-18 et seq., are specifically exempted from regulation. The exemptions from licensure must remain, unless these laws are changed.

N.J.A.C. 8:40-2.6 Surveys

COMMENT: One commenter suggested that a receipt be issued to the crew of a vehicle, after a licensure spot check is performed, in order to prevent multiple spot checks of the same vehicle on the same day.

RESPONSE: A multiple part spot check form is currently under development. One copy will be given to the vehicle staff after the spot check; another will subsequently be mailed to the provider's office. The third copy will be kept by the Department. Although this form may be shown to authorized representatives of the Department, the Department does not waive its right to conduct the additional spot checks.

COMMENT: Two providers questioned the use of "authorized representatives of the Department" to conduct surveys.

RESPONSE: As answered in the response to N.J.A.C. 8:40-2.4(i) above, nothing in the paragraph precludes the Chief Administrator, Emergency Medical Services from reviewing the vehicle and/or provider survey, when necessary. The Department declines to change the rule, since the Chief Administrator, like the Commissioner, must be able to delegate tasks in order that the work of the Department continue.

N.J.A.C. 8:40-2.7(f) Applications for provider licensure and/or vehicle licenses

COMMENT: Five non-governmental commenters questioned the exemption from licensure fees for governmental entities, and requested similar exemptions.

RESPONSE: It is the Department's practice to waive licensure fees for health facilities operated by government entities. The Department declines to change the practice in this instance, since the exemption of government agencies from fees is a Department policy of long standing and is widely applied.

N.J.A.C. 8:40-2.7(g) Applications for provider licensure and/or vehicle licenses

COMMENT: One commenter suggested that, if a Department survey cannot be done "within five working days," a provider be allowed to "certify under penalty of the law" that its new vehicle meets licensure criteria. The provider would then receive a temporary permit from a Department clerk, allowing the provider to use the vehicle until the Department survey could be done. Any deficiencies found during the survey would be subject to penalties.

RESPONSE: The Department cannot approve the use of services or vehicles prior to the appropriate survey and subsequent licensure. The Department declines to make this change, in the interest of public health and safety. Department experience indicates that this is the wisest course and it will not approve vehicles prior to survey, which, in most cases, is done wtihin five days.

N.J.A.C. 8:40-2.10(b) Vehicle licenses

COMMENT: Four commenters questioned the requirement that the original Department license be placed on the vehicle and that it must be readable from outside the vehicle. The commenters suggested that the window tint may be too dark to allow the license to be read easily.

RESPONSE: The requirement for display of the original license is to prevent misuse. The requirement that the license be readable from outside the vehicle is necessary for enforcing the rules and was prompted by difficulties in reading licenses attached to darkly tinted windows. It would be inappropriate for department representatives to open a vehicle's door, if the staff were not present, in order to read the license from the back. The public also should be able to read the information. Further, darkly tinted windows must be specially ordered, are more expensive than normal automotive industry tinted windows, and decrease the driver's view to the rear. Therefore, the requirement for the license to be readable in essence prohibits a darkly tinted window on the curbside rear door. The Department declines to change this requirement for display of the original license.

N.J.A.C. 8:40-2.11 Vehicle recognition number

COMMENT: Seven commenters asked for clarification of the Department's meaning of "unique non-duplicated number." One suggested that the Department assign the vehicle identification number.

RESPONSE: Department intent is to allow each provider to create its own vehicle numbering system. The unique non-duplicating limitation applies to each provicer individually and is intended to be a means for the department and the public to recognize different identically painted vehicles in a provider's fleet. The Department believes that the section is clear as written and declines to change it.

N.J.A.C. 8:40-2.13 Non-transferability

COMMENT: One commenter suggested that licenses should be transferable.

RESPONSE: Under N.J.S.A. 26:2H-12(b)2, the Department issues a license on finding: "... the premises, equipment, personnel, including principals and management, finances, rules and bylaws, and standards of health care service are fit and adequate and there is reasonable assurance the health care facility will be operated in the manner required ..." A license is granted to a provider and its vehicles, based on the investigations and surveys conducted through the Certificate of Need and licensure processes. Change in the ownership of the service or vehicle, therefore, necessitates voiding the license and completing the appropriate licensure process for the new owner. It serves to protect the public's interest. The Department declines to make a change.

N.J.A.C. 8:40-2.14(a) Return of vehicle license

COMMENT: One commenter suggested that there is "nothing so special about this piece of paper that it could possibly be used for any other purpose."

RESPONSE: The license must be returned to the Department to document that the vehicle has been permanently removed from the provider's fleet and to issue that the license will not be placed on an unlicensed vehicle. Department spot checks and surveys have documented that vehicle licenses have been misused in this way and prove the need for more vigorous Department enforcement of this requirement. The Department declines to make the requested change.

SUBCHAPTER 3. GENERAL REQUIREMENTS

N.J.A.C. 8:40-3.1(b) Agency ownership

COMMENT: One commenter wished a clarification on the percentage of stock transferred which would require a new Certificate of Need approval. Six commenters asked that the requirement be dropped.

RESPONSE: As explained in the response for N.J.A.C. 8:40-2.13 above, agency and vehicle licenses are not transferable. A transfer of stock changes the composition of company ownership and necessitates initiation of the appropriate approval and licensure processes before the new owner(s) can begin operation. The Department agrees it would be helpful to have more specific details regarding the percentage of stock or ownership transfer which constitutes a reportable change of ownership. It has added the specific percentages mentioned in N.J.A.C. 8:33-2.10 to N.J.A.C 8:40-3.1(b).

N.J.A.C. 8:40-3.1(d) Agency ownership

COMMENT: Two commenters specifically applauded the addition of this requirement.

RESPONSE: The Department agrees that the prohibition of future licensure to a principal or owner of a company whose license was revoked is necessary and proper.

N.J.A.C. 8:40-3.3(c) Standard operating procedures

COMMENT: Six commenters specifically applauded the changes to this subsection.

RESPONSE: The Department recognizes the need for clarification and additions to the staff manual.

N.J.A.C. 8:40-3.4(b) Business locations

COMMENT: Two commenters suggested that the Department change the wording to "within 30 days." Five additional commenters suggested the 30-day notification requirement be dropped entirely.

RESPONSE: The first part of the paragraph simply requires notification of all vehicle storage areas; no prior notification is attached. Reporting at the initiation of using the vehicle storage site would be sufficient. The second part of the paragraph requires 30-day prior notification when opening a satellite office. This is reasonable and proper and allows the

Department to determine whether the new location would necessitate Certificate of Need approval, and subsequent licensure as a separate entity, if the new location were not contiguous to the current service area. The Department declines to make this change.

N.J.A.C. 8:40-3.5(a)1 Report of unusual occurrences

COMMENT: Seven commenters asked the Department to remove the reference to "treatment in an emergency department" from this part of the rule.

RESPONSE: No patients are expected to die or to be injured in Invalid Coaches or Transport Ambulances. If a patient is killed or injured, the Department must be notified so it can investigate further. Treatment in an emergency department is one barometer of the severity of the situation; requiring a report to the Department is important. The Department has made one change to clarify the requirement. The word "while" has been added after the word "patients." This limits the reportable circumstances.

N.J.A.C. 8:40-3.5(a)2 Report of unusual occurrences

COMMENT: Seven commenters suggested this entire part of the rule be removed as duplicative.

RESPONSE: The key words in the subsection are, "injury ... which occurred while a patient was being treated ... transported." Injuries beyond those which prompted the original transport in the emergency ambulance, should not have occurred and should be reported. The Department declines to make this change.

N.J.A.C. 8:40-3.5(a)3 Report of unusual occurrences

COMMENT: Eight commenters suggested this entire part of the rule be removed as overburdensome.

RESPONSE: The Department has clarified this section by adding the words, "and which resulted in death, hospitalization, or treatment in an emergency department," after the word "roadway." This will change the circumstances to require the reporting of a traffic accident only when a person is injured or dies. Related followup information and reports (for example, a police report) need not be included in the original 72-hour written notification packet.

N.J.A.C. 8:40-3.5(a)4 Report of unusual occurrences

COMMENT: Four commenters asked that the Department remove the reference to "treatment in an emergency department" from this paragraph.

RESPONSE: A copy of the Worker's Compensation report will be accepted as written notification of injury or death to on-duty personnel. This should minimize paperwork in reporting such incidents, including when the personnel were treated in the emergency department. The Department reserves the right to require additional information in the course of any investigation.

N.J.A.C. 8:40-3.5(a)5 Report of unusual occurrences

COMMENT: Five commenters suggested that the Department should not require reporting of incidental or small fires which may occur. Two additional commenters suggested the removal of the words, "premises, vehicles."

RESPONSE: The Department agrees to remove the words, "premises, vehicles," since the intent of the Department is to safeguard and track records. Reporting of fires on the provider's premises and vehicles will only be required when there has been damage to records. This change restores N.J.A.C. 8:40-3.5(a)5 to its original wording.

N.J.A.C. 8:40-3.6(b) Advertising restrictions

COMMENT: Six commenters suggested removing this entire paragraph, claiming it would inhibit trade.

RESPONSE: The proposed paragraph merely states that longstanding policy of the Certificate of Need Program that a new Certificate of Need approval is required, if a provider changes the scope of service. Thus, a service which wishes to bid on a "street EMS" contract can only do so if provision of such services is within the scope of the provider's current Certificate of Need, or if the provider has been providing that level of care in that locale prior to the adoption of N.J.A.C. 8:40 in 1985. The Department declines to remove the provision.

N.J.A.C. 8:40-3.6(f) Advertising restrictions

COMMENT: Six commenters asked the Department to remove all references to Critical Care Transport Units (CCTUs) until the Department establishes specific CCTU standards.

RESPONSE: Critical Care Transport Units, a proposed new category of service which is still in the early discussion stages, will provide selected interfacility life support services. The intent of this requirement is to prohibit services from advertising a specific category of service that cannot yet be lawfully provided. The Department declines to change the proposal.

N.J.A.C. 8:40-3.7(a) Minimum personnel requirements

COMMENT: One commenter suggested that the subsection be changed to specifically require a New Jersey driver's license.

RESPONSE: Under N.J.S.A. 39:3-10 (Title 39, Motor Vehicle and Traffic Regulations), the New Jersey Division of Motor Vehicles (DMV) has jurisdiction in this area. Any business can contact DMV for details regarding out-of-State driver's licenses.

N.J.A.C. 8:40-3.7(b)1 Minimum personnel requirements

COMMENT: One commenter suggested that the minimum age for personnel should be changed back to age 18 because, "New Jersey allows ... driver's license at the age of 17, but that doesn't mean that they are now qualified to drive either an emergency vehicle or ... specialized equipment for transporting people."

RESPONSE: Although 17-year-olds can legally be certified as New Jersey Emergency Medical Technicians and can hold a New Jersey driver's license, the Department has received information from the U.S. Department of Labor which appears to preclude their employment with ambulance and invalid coach services. According to Fact Sheet ESA 86-3, 17-year-olds may be employed on any job not declared "hazardous" by the Secretary of Labor. Hazardous occupations include "... operating motor vehicles or working as outside helpers on motor vehicles ..." Further, the New Jersey Department of Labor, in its publication, "Volunteer Fire Companies, Rescue Squads, First Aid Squads and the New Jersey Child Labor Law," lists a number of activities applicable to ambulance and invalid coach services which are prohibited activities for minors under age 18. Therefore, the Department is returning the requirement to 18 years of age.

N.J.A.C. 8:40-3.7(b)2 Minimum personnel requirements

COMMENT: Five commenters suggested that the requirement for staff clothing "of a similar uniform appearance," which had been proposed for deletion, be retained.

RESPONSE: The Department agrees and will return these words to the rule, because a uniform appearance conveys a more consistent and professional image to the user of the service, and identifies the staff more clearly as employees of the service.

N.J.A.C. 8:40-3.7(d) Minimum personnel requirements

COMMENT: One commenter suggested that the Department require personnel to wear a patch or other identification showing the level of the individual's training. This would allow the public to easily recognize differences between the staff member's training levels.

RESPONSE: Some public safety services do not allow their staff to wear any patches or to deviate from the official service's uniform. The Department has never prohibited personnel from wearing patches or other identification appropriate to the level of training and to the level of care being given. Whether or not to require training identification to be worn is a matter left to each service's discretion. The Department has added a sentence to clarify its position regarding wearing of patches and other training identification.

N.J.A.C. 8:40-3.7(e)4 Minimum personnel requirements

COMMENT: Six commenters suggested that the Department delete the word, "unprofessional."

RESPONSE: The Department agrees and will delete the word, because the term is subjective.

N.J.A.C. 8:40-3.9(c) Maintenance of records

COMMENT: Seven commenters suggested that the Department change the number of years which a provider is required to keep medical records from 10 years to four years. They cited a number of agency standards, such as those of Medicare and the Internal Revenue Service, and the statute of limitations for civil tort actions in support of their request.

RESPONSE: The Department investigated the issue of medical record retention in response to these comments. As the Department investigated a possible change to four years, the Department found that the statute of limitations has been changed to allow suit to be brought by a patient, who was a minor at the time of care, until age 23 or 10 years after

treatment, whichever occurs later. Therefore, in accordance with the Department of State, Division of Archives and Records, the Department is changing the requirement for medical record retention to read, "for at least 10 years, or until age 23 for patients treated as minors, whichever occurs later."

N.J.A.C. 8:40-3.10(b) General vehicle requirements

COMMENT: Four commenters suggested that the subsection be changed to allow patients to be transported in a licensed ambulance or invalid coach for up to 72 hours after the vehicle received a reject sticker issued by the New Jersey Division of Motor Vehicles.

RESPONSE: To allow the use of a vehicle which has failed the Division of Motor Vehicles inspection process is not in the patient's best interest. The Department declines to make this change.

N.J.A.C. 8:40-3.10(e)4 General vehicle requirements

COMMENT: Six commenters suggested that the word "unbroken" be changed to "impervious" and implied that the meaning of the two words is the same.

RESPONSE: The Department's intent is to require an unbroken surface which is made from a material which is impervious. For clarity, the Department will add the word "impervious" after the word "unbroken."

N.J.A.C. 8:40-3.13(d) Restrictions on carbon monoxide concentrations

COMMENT: Seven commenters suggested that vehicles with diesel engines be excluded from carbon monoxide testing requirements because diesel engines do not produce carbon monoxide.

RESPONSE: The Department agrees and has added this exclusion.

N.J.A.C. 8:40-3.15 Required insurance coverage

COMMENT: One commenter suggested the addition of a requirement for Worker's Compensation insurance.

RESPONSE: Worker's Compensation insurance is already required under New Jersey law for any company which has one or more employees. There is no need to add the requirement here.

N.J.A.C. 8:40-3.15(a)2 Required insurance coverage

COMMENT: One commenter suggested that the general liability coverage be changed to $300,000 per occurrence with an aggregate of $600,000.

RESPONSE: The Department does not agree that an increase in coverage is necessary at this time. The premium cost of this increased coverage might overburden the providers and would have limited benefit to claimants. Therefore, the Department declines to make this change.

N.J.A.C. 8:40-3.15(a)3 Required insurance coverage

COMMENT: Two commenters suggested that professional liability "malpractice" type insurance should not be required for invalid coach services, because the commenters claim that no medical assistance is given to patients and the service's automobile insurance policy covers most of the incidents that could occur.

RESPONSE: The Department agrees that the level of exposure for medical incidents on an invalid coach is not as great as would be expected on an ambulance. Yet, there are some expenses and some possible incidents which are not covered under any automobile or general liability policy. For instance, it is the invalid coach driver's responsibility to monitor the patient, recognize a medical emergency if it occurs, and take appropriate action (examples include accessing the Emergency Medical Services system and starting cardiopulmonary resuscitation, if necessary). Therefore, in recognition of the lesser medical liability exposure for invalid coach services, the Department is changing the requirement to allow professional liability insurance, instead of malpractice type liability insurance, for invalid coach services. Providers which have ambulances in their fleets must continue to carry medical malpractice insurance to cover that portion of their services. This change should help to reduce provider insurance costs without negatively affecting patients' rights.

N.J.A.C. 8:40-3.15(a)4 Required insurance coverage

COMMENT: One commenter suggested that the Department delete this part of the rule and combine the coverage with N.J.A.C. 8:40-3.15(a)1 or 2, because the requirement for professional liability is redundant.

RESPONSE: As explained above in the response regarding N.J.A.C. 8:40-3.15(a)3, the Department does not agree that the requirement for professional liability insurance is redundant. The coverage of general liability "premises and operations" type insurance and the professional liability or malpractice policies can be insured under the same policy, as described in N.J.A.C. 8:40-3.15(a)4. The Department is adding the words, "or professional liability," after the word, "malpractice," as explained above.

N.J.A.C. 8:40-3.15(b) Required insurance coverage

COMMENT: One commenter suggested that the Department require insurance companies to change the wording on the Certificate of Insurance form to require notification to the Department, if the policy were cancelled for any reason. The commenter explained that some insurance companies will not notify the certificate holder, if the policy is cancelled by the insured.

RESPONSE: During the process of amending and readopting the rules, the Department combined some provisions of N.J.A.C. 8:40-3.15, Required insurance coverage, and N.J.A.C. 8:40-3.16, Provision of certificate of insurance. An original certificate of insurance is still required, but the necessity for providing a 10-day notice of cancellation has been deleted. Therefore, while the Department will continue to accept 10-day notices of cancellation, they are no longer required. Because the issue is moot, the Department declines to change the rule.

N.J.A.C. 8:40-3.15(e) Required insurance coverage

COMMENT: Two commenters suggested that the Department change the word "questionable" to "physically altered" to guard against forged documents.

RESPONSE: The intent of N.J.A.C. 8:40-3.15(e) does not involve a question of forgery; forgery is adequately covered under N.J.A.C. 8:40-3.9(a). The requirements for an updated Certificate of Insurance (as part of the annual relicensure process) and for the Department to receive a 10-day notice of cancellation were dropped in this proposal. The intent of this subsection is to require a provider's insurance carrier to submit a Certificate of Insurance upon the Department's request (at random) or if the Department suspects, or has reason to believe, that the required insurance is no longer in force. To clarify the intent, the Department is changing the paragraph to begin, "At the discretion of the Department, the licensee shall be required . . .", and deleting the original introductory text.

N.J.A.C. 8:40-3.18(b)2 Physical behavior restraints

COMMENT: Four commenters questioned whether the provider's staff have the jurisdiction to tell law enforcement officers that they must sit in the patient compartment.

RESPONSE: If a patient is in the custody of a law enforcement officer, and that officer applies handcuffs, it is unreasonable and unsafe for the ambulance personnel to be alone with the patient. Given the configuration of ambulances, it is impossible to closely observe a patient from the driver's compartment. Further, it is the Department's understanding that the patient cannot be "under arrest" unless he/she is accompanied by and supervised by a law enforcement officer. If the arresting officer is unwilling to closely supervise the patient, the ambulance staff should refuse to transport the patient.

SUBCHAPTER 4. SPECIFIC INVALID COACH REQUIREMENTS

N.J.A.C. 8:40-4.1 Patient restrictions

COMMENT: One commenter questioned whether a licensed invalid coach could be used to transport wheelchair-bound individuals for non-medical purposes or whether taxis could transport patients to doctors and hospitals.

RESPONSE: Nothing in the section prohibits the use of invalid coaches for non-medical transport. The Department does not regulate ambulatory transport, such as taxi service.

N.J.A.C. 8:40-4.3(b)1 Patient compartment requirements and dimensions

COMMENT: Five commenters, including the New Jersey Division on Aging, Transportation Care Company, Dial Inc., County of Bergen Office of Special Transportation, and On Time Transport Inc., stated that the current height requirements for invalid coaches were inadequate to safely load, unload and transport many wheelchair patients or ambulatory patients who are unable to bend their necks. They requested that the interior height and the doorway height of invalid coaches be increased. One of the commenters explained that a raised roof and door is also important for the driver's comfort and safety saying, "back problems can develop after being in that hunched position for extended periods of time. This wear and tear on the attendant can develop lazy habits when

securing the passenger." Another of the commenters said, "if a regulation is in the works to improve the safety of the invalid coaches in New Jersey it would only make sense to pass it."

RESPONSE: The Department agrees with the comments. Patient and staff safety (and comfort), as well as a new Federal standard, provide a compelling reason to increase the invalid coach height requirements. During the comment period, the Department investigated and received a copy of "National Workshop on Bus-Wheelchair Accessibility; Guideline Specifications for Active Wheelchair Lifts" published by the U.S. Department of Transportation (DOT). The publication states "the minimum height of the door opening at the wheelchair lift should be 56 inches . . . The 95th percentile male has a sitting height of 36.6 inches. Adding 19 inches for the seat height of the wheelchair results in an overall height of 55.6 inches . . . Interior vehicle height should be greater to accommodate movement inside vehicle." Further investigation showed that these recommendations were recommended for inclusion into new U.S. DOT requirements. The cost impact is minimal and reasonable. There would be a one-time cost of $2,000 to raise the roof and the door for each new vehicle (source: several vehicle manufacturers). The typical vehicle is used for five years (source: licensure records). Each vehicle is used about 225 days per year (source: Department review of provider files and information received from providers). The typical vehicle makes at least eight one-way transports per day (source: information from reimbursement agencies and providers). The estimated additional cost per vehicle would then be $400.00 per year, $1.78 per day, $.23 per one-way transport. The cost of a raised roof and door also may be off-set by a higher trade-in value for the vehicle and by potential reduced liability and Workers' Compensation expenses, because of the safer environment. The Department will require that all new vehicles submitted for licensure after March 1, 1993, have interior measurements of at least 58 inches between the floor and the ceiling and has modified N.J.A.C. 8:40-4.3(b) accordingly. New vehicles must also have a lift/ramp door opening at least 56 inches high, as outlined at N.J.A.C. 8:40-4.3(c)2. Existing low roof invalid coaches, licensed prior to March 1, 1993, as detailed in the new section N.J.A.C. 8:40-4.3(d), will be "grandfathered" for the life of the vehicle to the provider of record on that date. The life of such vehicles generally does not exceed three years, and repairs are usually accomplished within six weeks. Consistent with other rules for licensure, licensure must be applied for at the time of a change in ownership. In view of the Federal requirements, the relatively low cost, and the fact that the change will only affect future purchases of new vehicles (none of the current invalid coaches will be affected), the Department believes the change is warranted.

N.J.A.C. 8:40-4.3(b)3 Patient compartment requirements and dimensions

COMMENT: One provider questioned whether the Department would allow a shorter vehicle, which has room for at least one wheelchair.

RESPONSE: The standard length of 92 inches allows for the transport of three to four vehicles. If a provider wants to operate a less efficient vehicle which can transport only one or two wheelchairs, the provider should contact the Office of Emergency Medical Services for further technical assistance prior to ordering a smaller vehicle. Provisions have been made in the revised proposal at N.J.A.C. 8:40-4.3(b)3 to allow for shorter vehicles. There are currently two licensed "mini-van" invalid coaches in New Jersey.

N.J.A.C. 8:40-4.3(d)2 Patient compartment requirements and dimensions

COMMENT: One commenter suggested that the Department require a "walk-in door" to allow the driver easy egress in order to assist patients.

RESPONSE: Nothing in the proposed rules would prohibit an additional raised door. The driver currently has access by the use of the front passenger door, if the vehicle is equipped with a lift, or by walking up the wheelchair ramp. The driver has direct access to the patient from the driver's seat, when inside the vehicle. The Department declines to make this change.

N.J.A.C. 8:40-4.3(f)1 Patient compartment requirements and dimensions

COMMENT: One commenter suggested that the Department require all wheelchair positions to be forward facing and have a "Q-Straint"®, or equivalent, harness.

RESPONSE: The requirement for a restraint system which is not attached to the wheels of the wheelchair, such as the system mentioned, is already in the proposed rules. The Department declines to add a requirement for forward-facing wheelchair positions at this time, because this would require all the invalid coaches to be reconfigured, which would be economically infeasible at this time.

COMMENT: Six commenters suggested that the Department continue to accept wheelchair restraint systems which attach to the rear wheels of the wheelchair. One additional commenter suggested that the rear wheel restraint systems, currently on some licensed vehicles, be accepted for the life of the vehicle.

RESPONSE: The rear wheel "cam lock" style wheelchair restraint systems have never, by themselves, met the one-inch movement test. In every case, the addition of the front half of the track/strap wheelchair frame restraint system has been needed to bring the rear wheel restraint system into compliance with the rules. There are at least four manufacturers of a track/strap restraint system which attaches to the frame of a wheelchair. The track/strap wheelchair frame restraint systems are the only wheelchair restraint systems which have passed independent crash tests. The Department declines to allow the rear wheel "cam lock" systems to be used in newly licensed vehicles after March 1, 1993. However, it is adding a provision (N.J.A.C. 8:40-4.3(f)2) to "grandfather" the systems licensed prior to that date, provided the system otherwise meets requirements.

N.J.A.C. 8:40-4.4(a) Ramp or lift required

COMMENT: One commenter suggested that the Department require a fully automatic lift positioned at the rear door.

RESPONSE: The current rule provides flexibility in vehicle design in order to suit providers' individual needs. The Department declines to make this change.

N.J.A.C. 8:40-4.9 Oxygen administration devices

COMMENT: One commenter asked for clarification that oxygen devices were optional in an invalid coach and that the required Emergency Medical Technician needed to be present only during the times oxygen was on the vehicle.

RESPONSE: It is the Department's intent that oxygen remain optional in an invalid coach. The required Emergency Medical Technician need only be on board when oxygen is present.

N.J.A.C. 8:40-4.11 Required staff

COMMENT: Eight commenters questioned the requirement for the presence of a second staff member in order to move a wheelchair up or down stairs or when the patient weighed 200 pounds or more. The commenters feared the requirement would increase their costs and that the increase would have to be passed on to their patients. Several commenters stated that, under current "reimbursement rules," the provider would not be paid for the second staff member.

RESPONSE: The requirement for the second staff member, when a wheelchair patient needs to be brought up or down stairs, is a safety issue. The required training course for invalid coach drivers, Passenger Assistance Techniques (PAT), stresses the danger any time a wheelchair must be moved up or down stairs and requires two staff members to be involved in the maneuver. The proposed changes to this section match the Medicaid reimbursement rule, which do allow an additional payment for the second staff member. Medicaid and Department rules only require the second person while the patient is being brought up or down stairs. After the patient is on level ground, the second staff member may leave. This has been clarified in the rule.

N.J.A.C. 8:40-4.12 Required training of staff

COMMENT: One commenter suggested that the Department require the New Jersey Safety Council's Defensive Driving Course for all invalid coach drivers.

RESPONSE: Invalid coaches are not driven under emergency circumstances and the drivers are expected to obey all traffic laws. It is the provider's responsibility to train its drivers in the operation of its vehicles. The Department declines to make this change.

N.J.A.C. 8:40-4.12(a) Required training of staff

COMMENT: Six commenters suggested that Emergency Medical Technician (EMT) training be allowed as a substitute for the Passenger Assistance Techniques (PAT) training currently required for invalid coach personnel.

RESPONSE: EMT training is specific for ambulance service and does not cover the same course material as PAT; therefore, it cannot be used as a substitute. PAT training takes only about 14 hours to complete and has meant an improvement in invalid coach patient care. It would not

be a hardship for an EMT to also have PAT training. The Department declines to make this change.

N.J.A.C. 8:40-4.13(a)1 Duties of staff

COMMENT: Four commenters suggested that the words "appropriate care" be deleted as too relative a term.

RESPONSE: The term "appropriate care" is a standard, recognized term and provision of "appropriate care" is a necesary duty of staff. The Department declines to make this change.

SUBCHAPTER 5. SPECIFIC TRANSPORT AMBULANCE REQUIREMENTS

COMMENT: N.J.A.C. 8:40-5: One commenter suggested that the Department delete all emergency equipment from this category of vehicle.

RESPONSE: See response for N.J.A.C. 8:40-5.1(a) below.

N.J.A.C. 8:40-5.1(a) Restrictions on future licensing

COMMENT: Four commenters suggested that the Department continue to allow this category of vehicle. The commenters claimed that this is a cost-effective vehicle for routine transports. Two of the commenters suggested that the merits of transport ambulances be further evaluated.

RESPONSE: The Department's records show that there is a general lack of interest in this vehicle category, as evidenced by the declining number of new transport ambulance licensure applications. There were 16 new applications in 1989, seven in 1990 and only four through October 1991. Another indicator is the total number of transport ambulances: 35 licensed transport ambulances in 1990 and only 29 through October 1991. Some of the transport ambulances have been upgraded to emergency ambulances, others have been downgraded to invalid coach. Most have been removed from service by vehicle owners who have chosen not to replace them. Most providers have explained that the transport ambulances were not cost-effective because of the amount of emergency equipment required and the necessary patient restrictions, which would not allow the vehicle's use for undiagnosed patients. The Department was specifically required to include the emergency equipment in order to comply with Medicare and Medicaid reimbursement rules. Deleting the emergency equipment would mean that providers could not bill either agency for transport ambulance runs. Although the industry is welcome to reevaluate the future need for a nonemergency, transport-type ambulance vehicle, keeping in mind the need for reimbursement, the Department, based upon existing data, declines to change the proposal.

SUBCHAPTER 6. SPECIFIC EMERGENCY AMBULANCE REQUIREMENTS

COMMENT: Six commenters suggested that the Department eliminate all references to equipment and supplies "approved by the Commissioner."

RESPONSE: There is no Federal regulatory agency which is responsible for testing and/or approving most of the equipment and supplies which are used in the prehospital setting. Therefore, some of the items which come to market for use on ambulances and invalid coaches are of questionable benefit and sometimes are even harmful. As the chief health officer of the State, the Commissioner of Health has resources at his or her disposal which can evaluate and make recommendations about the safety and efficacy of items intended for use in the prehospital setting. Further, by leaving the choice of devices somewhat open-ended (that is, "approved by the Commissioner"), the rules can remain flexible enough to adopt new technology which proves to be safe and effective. Retaining the proposed wording is in the best interests of both the public and the prehospital providers; the Department declines to make the change suggested in the comments.

N.J.A.C. 8:40-6.1(a)3 Patient restrictions

COMMENT: Two commenters suggested that this deleted sentence be returned to the rules.

RESPONSE: Aspiration is already a permitted activity under N.J.A.C. 8:40-6.1(a)1. The observation of intravenous fluids and/or medications is beyond the basic life support training of the emergency medical technician staff. Although, these patients can be transported on an emergency ambulance by adding specially-trained staff, it is confusing to include these special patients in this list. The Department declines to change the text.

N.J.A.C. 8:40-6.3(f)1 Patient compartment requirements and dimensions

COMMENT: Three commenters suggested that the Department continue to accept wheelchair restraint systems which attach to the rear wheels of the wheelchair.

RESPONSE: The rear wheel "cam lock" style wheelchair restraint systems have never, by themselves, met the one-inch movement test. In every case, the addition of the front half of the track/strap wheelchair frame restraint system has been needed to bring the rear wheel restraint system into compliance with the rules. There are at least four manufacturers of a track/strap restraint system which attaches to the frame of a wheelchair. The track/strap wheelchair frame restraint systems are the only wheelchair restraint systems which have passed independent crash tests. The Department declines to allow the rear wheel "cam lock" systems to be used in newly licensed vehicles after March 1, 1993. However, it is adding a provision (N.J.A.C. 8:40-6.3(f)2) to "grandfather" the systems licensed prior to that date, provided the system otherwise meets requirements. A similar provision was also added to the "Patient compartment requirements and dimensions" in Subchapters 4 and 5.

N.J.A.C. 8:40-6.5(c)1 Certification to Federal specifications

COMMENT: Two commenters suggested that the Department allow white flashing emergency lights, as called for in the Federal KKK-A-1822 specifications. These commenters made the same comment about N.J.A.C. 8:40-6.8(b), Emergency warning devices.

RESPONSE: New Jersey Division of Motor Vehicle rules do not allow any vehicle registered in New Jersey to have white flashing lights. The Department cannot make these changes.

N.J.A.C. 8:40-6.5(c)3 Certification to Federal specifications

COMMENT: Six commenters suggested that the Department change the standard for the free airflow of aspirators to 20 lpm from 30 lpm.

RESPONSE: A 30 lpm flow rate is a long standing, nationally recognized, medical standard, supported by clinical data. The Department has been unable to find any clinical criteria to support the lower 20 lpm standard listed in the Federal KKK-A-1822 specification. Further, the Department has investigated the use of the Federal KKK-A-1822 specification and has found, for example, that the Department of Defense's purchases of portable aspirators over the past few years have specified a 30 lpm flow and a battery life, at standard, of 30 minutes.

N.J.A.C. 8:40-6.6(a) Ramp or lift

COMMENT: Four commenters suggested that the word, "securely" be returned to the section and the word, "permanently" be removed.

RESPONSE: This change was made to clarify the Department's intent that temporary ramps (which are not bolted to the vehicle) are not, and have never been, allowed. The word "securely" has been misinterpreted in this regard, thus making the clarification necessary. The Department declines to make the suggested change at N.J.A.C. 8:40-6.6(a).

N.J.A.C. 8:40-6.7(f)2 Vehicle markings

COMMENT: Six commenters wanted clarification of the phrase, "... or any other wording which would imply the provision of advanced life support ..." The commenters were concerned that the Department could arbitrarily dictate a provider's corporate name.

RESPONSE: The Department must insure that only those services legally eligible to provide advanced life support, as defined in N.J.S.A. 26:2K-7 et seq., can be allowed to advertise those services to the public. Vehicle markings, including trade names and symbols, are a highly visible form of advertising. The Department licenses a provider by its trade name, not necessarily by its corporate name, unless the corporate name is used in some form of advertising or in public contact. The Department declines to change this requirement.

N.J.A.C. 8:40-6.14(a) and (b) Resuscitation devices

COMMENT: Four commenters suggested that the Department delete the requirement for an oxygen-powered resuscitator.

RESPONSE: The Department has not found any data to support deleting this requirement. The Department will keep this request for possible future consideration, but declines to make the requested change at this time.

N.J.A.C. 8:40-6.14(c) Resuscitation devices

COMMENT: Four commenters requested assistance in finding vendors for the child-sized bag-valve-masks listed in N.J.A.C. 8:40-6.14(c).

RESPONSE: Child-sized bag-valve-masks have always been required. The bag volume (700 to 750cc for "infants") listed in the present version of N.J.A.C. 8:40, actually matches the average child-sized bag. The proposed change corrects that error and adds the requirement for a true infant-sized bag-valve-mask resuscitator. The specific volume requirements have been deleted to allow for a greater range of manufacturers. All three sizes are manufactured by a wide range of companies. They are readily available from mail order firms and through all of the ambulance equipment vendors in New Jersey.

N.J.A.C. 8:40-6.15(b) Aspirator/suction devices

COMMENT: Six commenters suggested that the Department change the requirement that portable aspirators be able to continuously function from 20 minutes to 10 minutes.

RESPONSE: It is reasonable to need a portable aspirator, which can produce the required flow for more than 20 minutes, during a motor vehicle extrication or when removing a patient from a three-story walk-up apartment. The patient deserves the highest possible level of care. The portable aspirators regularly seen on New Jersey ambulances are manufactured to exceed this standard. As explained in the response to N.J.A.C. 8:40-6.5(c)3 above, some Federal government purchases require 30-minute duration. It is the provider's responsibility to maintain the battery according to the manufacturer's instructions. Vehicle licensure surveys conducted over the past years have clearly shown that most failures are due to improper maintenance. The Department declines to make this change.

N.J.A.C. 8:40-6.15(c) Aspirator/suction devices

COMMENT: Six commenters repeated the request for a 20 lpm standard.

RESPONSE: The Department declines to make this change, as explained in the response to N.J.A.C. 8:40-6.5(c)3, above.

N.J.A.C. 8:40-6.15(d) Aspirator/suction devices

COMMENT: Four commenters suggested that the Department delete the proposed requirement for an infant bulb syringe.

RESPONSE: A bulb syringe is the equipment of choice for infant aspiration. It is not expensive and is safer to use on these patients than a mechanical aspirator would be. The Department declines to make this change.

N.J.A.C. 8:40-6.17 External cardiac compression support

COMMENT: Six commenters suggested that the Department delete the words, "It shall not be stored under the bench seat."

RESPONSE: This is a clarification of the Department's definition of "immediately available." The Department has never allowed the CPR board to be stored under the bench seat.

N.J.A.C. 8:40-6.18(a)8 Spine boards, orthopedic litter and splints

COMMENT: Three commenters suggested that the Department delete the requirement for a traction splint because, they said, traction splints were no longer being used in the field.

RESPONSE: Traction splints remain the treatment of choice for uncomplicated (closed) fractures of the femur, and in some cases for open fractures as well. Traction splints are the currently published national standard of care, as it appears in the U.S. Department of Transportation's training curricula for Emergency Medical Technicians at the basic, intermediate and advanced life support (paramedic) levels. Any liability for failing to follow the recognized national standard of care will fall on the provider and the individual staff involved. The Department would be remiss to delete this required equipment and declines to make the suggested change.

N.J.A.C. 8:40-6.19(a)2 Wound dressing and burn treatment supplies

COMMENT: Six commenters suggested that the Department delete the requirement for 24 triangular bandages (cravats), when a wooden short spine board is used.

RESPONSE: The Department agrees and is changing the section to require 12 cravats, regardless of the type of spinal immobilization device carried on the vehicle, since there are a number of spine immobilization devices. The number needed should not be more than 12; 24 is an excessive number, since there are other alternatives in patient care which can be utilized.

N.J.A.C. 8:40-6.20 Obstetrical Kit

COMMENT: Four commenters suggested tha the word "sterile" be deleted wherever it occurs in the section, because there is no threat of infection.

RESPONSE: The Department disagrees with the comment. There is a very definite risk of maternal post-partum infection when birth occurs in the prehospital setting. The Department declines to make this change.

N.J.A.C. 8:40-6.20(a)1 Obstetrical kit

COMMENT: Six commenters suggested that the Department return to the requirement for four towels.

RESPONSE: The Department agrees and is making this change, since the number required is adequate to handle an obstetrical emergency.

N.J.A.C. 8:40-6.20(a)6 Obstetrical kit

COMMENT: Four commenters suggested that the Department return to the requirement for three pairs of sterile gloves.

RESPONSE: The requirement was increased to allow each of the two required Emergency Medical Technicians to have an extra pair of gloves, in the event the gloves break or become contaminated or overly soiled. The Department declines to make this change.

N.J.A.C. 8:40-6.20(a)8 Obstetrical kit

COMMENT: Six commenters suggested that the proposed requirement for goggles be deleted.

RESPONSE: The goggles are necessary eye protection to the staff directly involved in monitoring and assisting with the birth. The Department declines to make this change.

N.J.A.C. 8:40-6.20(a)9 Obstetrical kit

COMMENT: Seven commenters suggested that the Department delete the proposed requirement for a box of sanitary pads and suggested that trauma dressings could serve the intended purpose.

RESPONSE: The Department agrees and is deleting the requirement for sanitary pads.

N.J.A.C. 8:40-6.21(a)2 Poison treatment supplies

COMMENT: Six commenters suggested that the Department return to the requirement for one packet of activated charcoal.

RESPONSE: According to the New Jersey Poison Information and Education System, liquid activated charcoal is easier to administer and less trouble to use than dry activated charcoal. The liquid product replaces the previous requirement for dry activated charcoal. Four doses of both liquid activated charcoal and Syrup of Ipecac are required because multiple family members (especially children) may be poisoned at the same time and some patients require multiple doses. The Department does not agree that the items or the amounts are "duplicative" and declines to change the requirement.

N.J.A.C. 8:40-6.22(a)4 Other patient care equipment

COMMENT: Four commenters suggested that the Department require only two blankets year round.

RESPONSE: Two blankets are insufficient for winter transports or for runs on which there is more than one patient. Licensure surveys conducted by the Department have not shown difficulty with storing four blankets. Two heavy blankets and two lighter blankets are adequate to meet the requirement. The Department declines to make this change.

N.J.A.C. 8:40-6.22(a)5 Other patient care equipment

COMMENT: Six commenters suggested that the Department allow a flashlight to be used in lieu of a penlight.

RESPONSE: A flashlight is not a substitute for a penlight during patient examination. Penlights are commonly used for examining patient's eyes; flashlights are typically too strong for this type of use. As clarification, the penlight may be part of the company uniform and be carried by the individual staff members, as detailed in the provider's Standard Operating Procedures. The Department declines to make this change.

N.J.A.C. 8:40-6.22(a)6 Other patient care equipment

COMMENT: Four commenters suggested that the Department delete the proposed requirement for hot and cold packs.

RESPONSE: The Department agrees and is deleting this requirement, because hot and cold packs would lose their proper temperature due to varying storage temperatures of the vehicle.

COMMENT: Six commenters suggested that the Department delete the proposed requirement of four towels, as it duplicated the requirement for towels in the obstetrical kit.

RESPONSE: The towels which are packaged in an obstetrical kit are thin, paper type towels. The towels intended here are the standard "hospital type" towels which have a multitude of uses on an ambulance. Most ambulances surveyed by Department staff already carry these towels. The Department declines to make this change.

N.J.A.C. 8:40-6.22(a)8 Other patient care equipment

COMMENT: Six commenters suggested that the Department delete the proposed requirement for six plastic bags.

RESPONSE: Plastic bags take up a minimum of storage space, are already carried on most ambulances surveyed by Department staff, and can be very useful in a variety of circumstances. The choice of sizes is left up to each provider. The Department declines to make this change.

N.J.A.C. 8:40-6.22(a)9 Other patient care equipment

COMMENT: Six commenters suggested that the words, "surgeon's type," be changed to the word, "latex."

RESPONSE: The Department agrees in principle and is adding the word "latex" to better define "surgeon's type." The Department will make an identical change to N.J.A.C 8:40-5.20(a)6.

N.J.A.C. 8:40-6.22(a)10 Other patient care equipment

COMMENT: Six commenters suggested that goggles be added to the items required in this paragraph.

RESPONSE: The Department agrees and is adding a requirement at N.J.A.C. 8:40-6.22(a)6 for an additional pair of goggles to supplement the pair already required in the obstetrical kit.

N.J.A.C. 8:40-6.24(a)2 Safety equipment

COMMENT: Six commenters suggested that the proposed requirement for flares, which are to be used when aeromedical transport is required, be deleted because flares are dangerous.

RESPONSE: The Department agrees that flares can be dangerous. The aeromedical programs specifically requested that flares be included so they can be used to mark a helicopter landing zone. The Department will monitor the use of flares in the prehospital setting, but declines to change the proposal at this time.

N.J.A.C. 8:40-6.24(b) Safety equipment

COMMENT: One commenter suggested that the Department add a requirement for binoculars. Use of binoculars when responding to an accident is encouraged in hazardous materials training courses so that ambulance staff can more easily determine if there are possible hazardous substance complications at the accident site.

RESPONSE: The Department will take this request under advisement for future revisions, but declines to make the change at this time.

N.J.A.C. 8:40-6.26 Required training of staff

COMMENT: One commenter suggested that the Department allow providers to have only one staff member, an individual trained to the invalid coach driver (Patient Assistance Techniques) level, on board whenever the ambulance is being used as an invalid coach.

RESPONSE: The ambulance bulkhead makes it impossible for the driver to see and monitor the patient, who would be all alone in the back of the ambulance, if there were no attendant. The use of a licensed ambulance for invalid coach transport is optional; providers may use a less-expensive-to-operate invalid coach vehicle. Two currently certified Emergency Medical Technicians, with current CPR certification, is the minimum standard for emergency ambulance staff. The Department declines to make the suggested change.

N.J.A.C. 8:40-6.26(a) Required training of staff

COMMENT: One commenter asked if a New Jersey paramedic, registered professional nurse or a physician could take the place of an Emergency Medical Technician (EMT).

RESPONSE: A New Jersey certified paramedic is also certified as an EMT and can operate at the basic life support level, when working for a provider licensed under these rules. He or she should not wear paramedic identification under these circumstances, however. A New Jersey registered professional nurse needs to complete a special training program to be cross trained and certified as an EMT, before working as one of the two required EMTs on an ambulance. A New Jersey licensed physician can, and always could, be a substitute for a required EMT.

N.J.A.C. 8:40-6.26(c) Required training of staff

COMMENT: One commenter commended the Department for requiring annual CPR certification.

RESPONSE: The Department appreciates the comment.

N.J.A.C. 8:40-6.27(a)5 Duties of staff

COMMENT: Six commenters suggested that the Department delete the proposed requirement that child passengers be restrained in a Federally approved child safety seat. The commenters suggested that such a seat would be expensive and nearly impossible to store safely on most ambulances.

RESPONSE: The Department agrees that there is little room to safely store a child passenger safety seat on most ambulances and is deleting the proposed requirement. The requirement for a child passenger safety seat has also been removed from N.J.A.C. 8:40-5.24(a)4. This does not affect the proposal for the optional Federally approved child patient transport seat, as defined in N.J.A.C. 8:40-5.11(e) and 6.11(e).

N.J.A.C. 8:40-6.27(a)11 Duties of staff

COMMENT: One commenter commended the Department for prohibiting smoking throughout the vehicle.

RESPONSE: The Department appreciates the comment.

N.J.A.C. 8:40-6.28(a)1 and 2 Special staff required

COMMENT: Two commenters suggested that the Department allow a basic Emergency Medical Technician (EMT) to substitute for the special staff. They further recommended that any special staff be considered to be a part of, not an addition to, the regular ambulance staff.

RESPONSE: The Department does not agree that an EMT can substitute for members of the specially trained medical team, since the training is not comparable. The Department declines to make the change. The Department partially agrees with the second comment and is changing N.J.A.C. 8:40-6.28(a)1 to read, "At least one of the two persons . . ." This will allow the provider to supply only one EMT (the driver) for neonatal transports, as there is no need for an EMT attendant in this specific instance.

COMMENT: Four commenters suggested that the Department return to the old language of this section and not require a physician as part of the special neonate transport team. The commenters further explained that the qualifications of staff sent by the hospital are beyond their control.

RESPONSE: The recognized standard of care for neonate transfers includes a physician on the transport team. Since the physician and either the nurse or respiratory therapist are generally assigned by the hospital, it would be the hospital's responsibility to ensure that transport team members are appropriately trained and/or certified. The Department declines to make this change.

N.J.A.C. 8:40-6.28(c) Special staff required

COMMENT: One commenter expressed concern that the future regulation of Critical Care Transport Units (CCTUs), mentioned in this subsection, would block licensed basic life support providers from continuing the interfacility transports they currently provide. Another commenter did not wish the Department to create separate CCTU rules and said, "The creation of a new rule would create confusion and costly duplication of services."

RESPONSE: The inclusion of the subsection at this time will allow these rules to dovetail with any future CCTU rules, without the need for further revision of N.J.A.C 8:40. Any comments on Critical Care Transport Units, including the services which would be covered and who would provide the services, should be made at the time CCTU rules are proposed.

N.J.A.C. 8:40-6.30(f) and (h) Radio communications

COMMENT: Seven commenters suggested that all references to nursing homes be removed from these paragraphs. The commenters explained that requiring additional radio equipment would be "burdensome and unnecessary" in these instances.

RESPONSE: The Department agrees and is deleting the references to nursing homes in these subsections because, in most circumstances, such runs are not emergencies. This type of vehicle would not participate routinely in disasters and would not need these frequencies. Should the vehicle need to communicate, two other channels are available.

COMMENT: One commenter suggested that a package of 50 standard medical triage tags (METTAG®) and a complete triage kit be carried on every emergency ambulance which provides "street EMS."

RESPONSE: The Department agrees with the first suggestion and is adding N.J.A.C. 8:40-6.31(c), which requires a package of 50 medical emergency triage tags (METTAG®), since these vehicles are likely to be first respondees. The Department is taking the second suggestion under advisement for future consideration.

N.J.A.C. 8:40-6.31(a) and (b) Disaster planning required

COMMENT: Two commenters suggested that the Department delete the entire section. They stated that individual jurisdictions, in conjunction with the Office of Emergency Management, should decide these requirements.

RESPONSE: This section relates only to the Emergency Medical Services (EMS) aspects of the local or regional disaster plan. Specific EMS plans are often contained in an "annex" to county or municipal written plans. The EMS annex should be created with the input from the provider(s) of "street EMS" and the plan should be tested regularly. The Department declines to make this change.

SUBCHAPTER 7. SPECIFIC HELICOPTER AMBULANCE REQUIREMENTS

There were no comments received regarding this subchapter.

Summary of Agency-Initiated Changes:

In addition to the changes made as a result of comments received, technical changes have been made at various points in the rule, including N.J.A.C. 8:40-5.1(a) where the date of March 1, 1993, was substituted for the wording, "one year from the operative date."

The sentence in N.J.A.C 8:40-3.13(c) which begins "Carbon monoxide shall not enter . . ." was mistakenly proposed for deletion and has been returned to the rule.

Consistent with the Department's intent that the two-year licensure begin with the relicensure cycle after the new rules take effect, one year was added to each year listed in the rules (for example, 1992 becomes 1993). Preparations for calendar year 1992 licensure have already begun.

A minor change in recognized testing criteria for oxygen flowmeters was left out of the proposal in error. The change in criteria will allow for more flexibility in testing and is being added now at N.J.A.C. 8:40-4.9(e), 5.12(d), and 6.13(d), Oxygen administration devices, the appropriate paragraphs in the Invalid Coach, Transport Ambulance, and Emergency Ambulance rules respectively.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:40.

Full text of the adopted amendments follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 40

MANUAL OF STANDARDS FOR LICENSURE OF INVALID COACH AND AMBULANCE SERVICES

SUBCHAPTER 1. DEFINITIONS

8:40-1.1 Definitions

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

"Advanced life support" means an advanced level of prehospital, interhospital, and emergency service care which includes basic life support functions, cardiac monitoring, cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other techniques and procedures authorized in writing by the Commissioner, as governed by N.J.S.A. 26:2K-7 et seq. and N.J.A.C. 8:41.

. . .

"Basic life support" means a basic level of prehospital care which includes patient stabilization, airway clearance, cardiopulmonary resuscitation, hemorrhage control, initial wound care and fracture stabilization, and other techniques and procedures authorized by the Commissioner.

"Certificate of need" means a State authorized permit to construct or expand a health care facility or to institute a new health care service, in accordance with requirements at N.J.A.C. 8:33.

. . .

"Conditional vehicle permit" means a 45-day permit given to a vehicle which does not meet all licensure criteria to allow time for correction of specific non-lifethreatening deficiencies and to allow the vehicle to be used during that period.

"Crashworthy" means that supplies, equipment, oxygen systems, patient litters and wheelchairs will remain firmly in place during a serious accident or vehicle rollover. Crashworthy retention systems may not incorporate rubber straps or Velcro® closures. Crashworthy retention systems for some items are covered by specific Federal standards, as noted in this chapter. The Department's test for crashworthiness of other retention systems is whether the item can be removed from place without unlatching or unbuckling the retention system.

. . .

"Emergency" means an individual's perceived need for immediate medical care in order to prevent death or aggravation of physiological or psychological illness or injury.

"Emergency medical technician—Ambulance (EMT-A)" means an individual trained and currently certified by the Commissioner, in accordance with the United States Department of Transportation EMT-A training course, as outlined in the standards established by the Federal Highway Safety Act of 1966, 23 U.S.C. 401 et. seq. (amended), to deliver basic life support services, and who has completed the national standard curriculum, as published by the United States Department of Transportation for Emergency Medical Technician-Ambulance and who is affiliated with an emergency medical services organization.

. . .

"Federal Specification KKK-A-1822" means the specification and amendments thereto in force at the time of vehicle manufacture and entitled "Federal Specification, Ambulance, Emergency Medical Care Surface Vehicle KKK-A-1822" as published by the Federal Supply Service of the U.S. General Services Administration. Copies of the specification may be obtained by contacting:

General Services Administration
Specification Section (3FBP-W), Room 6654
7th and D Streets, SW
Washington, D.C. 20407

. . .

"Helicopter ambulance service" means those services which provide aeromedical emergency care and transportation by rotowing aircraft and which are either provided to patients located in New Jersey by out-of-State providers or are provided by the New Jersey State Police.

"Impervious" means not allowing liquids or dirt to penetrate the surface of the material.

"Invalid coach service" means the provision of non-emergency health care transportation, by certified trained personnel, for sick, infirm or otherwise disabled persons who are under the care and supervision of a physician ***, or other recognized health care provider,*** and whose medical condition is not of sufficient magnitude or gravity to require transportation by ambulance, but does require transportation from place to place for medical care, and whose use of an alternate form of transportation, such as taxicab, bus, other public conveyance or private vehicle, might create a serious risk to life and health.

. . .

"In-service" means the presence of the vehicle at a health care facility or other place of medical care or picking up, transporting, or discharging any patient.

"Inter-hospital care" means those emergency medical services rendered by emergency or transport ambulances and their crews to patients before and during transportation between emergency treatment facilities, and upon arrival within those facilities.

"International symbol of access for the handicapped" means the outline form of a person in a wheelchair.

...

"JEMS communication plan" means the State of New Jersey Emergency Medical Services Communication Plan published by the Department. Single copies of the plan are available, at no charge, from EMS, CN 364, Trenton, NJ 08625-0364.

...

"Paramedic" means a person who is trained in advanced life support services and who is certified as a mobile intensive care paramedic by the commissioner (under N.J.S.A. 26:2K-7 et seq.) to render advanced life support services as part of a mobile intensive care unit.

"Patient" means any person utilizing services licensed under this chapter, including an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, and excluding deceased individuals being transported from or between private or public institutions, homes or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance.

"Payment for services" means monies received for providing, or promising to provide, patient care, including, but not limited to, fee-for-service, subscription plans, contracts, or salaries for staff members, but excluding receipt of funds which may be donated to a volunteer first aid or rescue squad by a municipality in the amount of or less than the donation limit prescribed by law.

"Pneumatic Testing Guide" means the Pneumatic Testing Guide (for Pre-Hospital Respiratory Equipment) published by the Department. Single copies are available, at no charge, from EMS, CN 364, Trenton, NJ 08625.

...

"Staff" means anyone working on the vehicle, including the medical crew and the driver, who is providing care to the patient or operating the vehicle.

"Star of Life" means the symbol described in certification of registration number 1,058,022 which the United States Commissioner of Patents and Trademarks has issued to the National Highway Traffic Safety Administration.

...

"Volunteer first aid, rescue or ambulance squad" means a first aid, rescue or ambulance squad which provides emergency medical services without receiving payment for those services.

SUBCHAPTER 2. AUTHORITY AND LICENSURE PROCEDURES

8:40-2.2 Application of regulations

(a) This chapter shall apply to all Ambulance and Invalid Coach companies providing service in New Jersey, unless exempted under N.J.A.C. 8:40-2.5

Recodify (a)-(d) as (b)-(e) (No change in text.)

8:40-2.3 Certificate of need required

(a) (No change.)

(b) Application forms for a Certificate of Need and instructions for completion may be obtained from:

Certificate of Need Program
Division of Health Planning and Resources Development
New Jersey State Department of Health
CN 360
Trenton, NJ 08625-0360

(c) Licensed services and municipalities providing emergency ambulance services ("street EMS") cannot discontinue services without sending written notification to the Department at least *[90]* **60** days prior to the planned closure date and receiving certificate of need approval.

8:40-2.4 Licensing requirements

(a) (No change.)

(b) Provider licensing shall consist of two types of licenses:

1. A six-month temporary provider permit issued by the Department which authorizes the licensee to provide one or both of the following:

i.-ii. (No change.)

2. (No change.)

(c) Vehicle licensing shall consist of a 45-day conditional permit or a license issued by the Department for a specific vehicle which authorizes the licensee to utilize the vehicle to provide:

1.-4. (No change.)

(d) (No change.)

(e) Vehicles licensed to provide Transport Ambulance Service may be utilized to provide Invalid Coach Service provided:

1. (No change.)

2. The vehicle, equipment, supplies and staffing continue to comply with the requirements for Transport Ambulance Service.

(f) Vehicles licensed to provide Emergency Ambulance Service may be utilized to provide Invalid Coach Service provided:

1. (No change.)

2. The vehicle, equipment, supplies and staffing continue to comply with the requirements for Emergency Ambulance Service.

(g) Vehicles licensed to provide Emergency Ambulance Service may be utilized to provide Transport Ambulance Service provided the vehicle, equipment, supplies and staffing continue to comply with the requirements for Emergency Ambulance Service, as set forth in N.J.A.C. 8:40-1, 2, 3 and 6.

(h) (No change.)

(i) At the discretion of the authorized representative of the Department, a 45-day conditional permit may be issued to vehicles which do not meet full licensure criteria, but whose deficiencies do not constitute a threat to patient or staff safety. A conditional permit may be considered only for a vehicle upon initial presentation for licensure; vehicles undergoing relicensure are ineligible for a conditional permit.

8:40-2.5 Exemptions from licensing requirements

(a) In accordance with the provisions of N.J.S.A. 30:4D-6.2 et seq. and N.J.S.A. 26:2H-1 et seq., this chapter shall not apply to Invalid Coach Services or Ambulance Services provided by volunteer first aid, rescue and ambulance squads as defined in the "New Jersey Highway Safety Act of 1987" (N.J.S.A. 27:5F-18 et seq.).

(b) This chapter shall not apply to providers which are based in other states and which provide service in New Jersey when the provider is:

1. Transporting a patient through New Jersey from an out-of-State location to another out-of-State location; or

2. Transporting a patient from an out-of-State location to a New Jersey location and returning that same patient to an out-of-State location on the same calendar day; or

3. Transporting a patient on a one-way trip from an out-of-State location to a New Jersey location.

(c) The provisions of this chapter will not apply to services provided directly by an agency of the government of the United States. Providers holding government contracts do not meet this criterion and are not exempt from licensure.

(d) (No change.)

8:40-2.6 Surveys

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

(c) In recognition of the necessity to determine compliance with all sections of this chapter, authorized representatives of the Department may survey a vehicle whenever it is in-service provided that no representative of the Department shall stop any vehicle when it is traveling on a public road.

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

(g) The Department shall notify the licensee in writing of any survey results (positive or negative).

8:40-2.7 Applications for provider licensure and/or vehicle licenses

(a) Following acquisition of a Certificate of Need, any person, public or private institution, agency or business concern desiring to be licensed or relicensed to operate Invalid Coach Services and/or Ambulance Services or to secure a vehicle license shall apply to the Commissioner on forms prescribed by the Department. Forms are available from:

Office of Emergency Medical Services
New Jersey State Department of Health
CN 364
Trenton, NJ 08625-0364

(b) The Department shall charge an annual non-refundable fee of $50.00 for the filing of an application to license, or relicense, a provider. Services receiving two-year licenses will be charged an amount twice the annual fee.

(c) The Department shall charge an annual non-refundable fee of $20.00 for the filing of an application to license, or relicense, each vehicle. Vehicles receiving two-year licenses will be charged an amount twice the annual fee.

(d) Beginning with licensure year *[1992]* ***1993***, services with names beginning with the letters A-L will be issued two-year licenses. For licensure year *[1992]* ***1993***, services with names beginning with the letters M-Z will be issued one-year licenses. Beginning with licensure year *[1993]* ***1994***, services with names beginning with the letters M-Z will be issued two-year licenses. Subsequent applications for relicensure will be on a two-year cycle by alphabetical grouping, although services may be resurveyed annually for quality assurance purposes. New services which apply for licensure mid-cycle will be issued a license for the appropriate alphabetical timeframe and will be charged the applicable one-year or two-year fee.

(e) Each set of application(s) submitted to the Department shall be accompanied by a single check in the correct amount made payable to "Treasurer, State of New Jersey."

(f) Governmental entities, such as municipalities and State agencies, are exempt from paying the application fees listed in (b) and (c) above, but must file the appropriate applications.

(g) Upon receipt of the required application forms, authorized representatives of the Department shall survey (or resurvey) the licensee and/or the vehicles to determine compliance with this chapter.

(h) The Department shall notify the licensee in writing of any deficiencies found during surveys.

8:40-2.9 Full provider license

(a) The licensure year extends from January 1 to December 31 of the same calendar year. Beginning in licensure year *[1992]* ***1993***, two-year licensing will be phased in, as described in N.J.A.C. 8:40-2.7(d).

(b) A full license, valid for a period of 12 months or less, until December 31, *[1991]* ***1992***, or 24 months or less after January 1, *[1992]* ***1993***, shall be issued on expiration of the temporary permit, if periodic surveys by the Department have determined that the licensee is in compliance with this chapter.

(c) The full license, unless sooner suspended or revoked, shall be renewed prior to its expiration date, as noted on the license, contingent upon the licensee:

1.-2. (No change.)

(d) (No change in text.)

8:40-2.10 Vehicle licenses

(a) Upon finding that the vehicle and required equipment are in compliance with this chapter, the Department shall issue a license or permit for the vehicle. Except as provided in N.J.A.C. 8:40-2.4 (c), the license or permit shall be valid for the same period as the temporary provider permit or full license.

(b) The original vehicle license or permit shall be affixed to the lower right corner of the window of the rear (curb side) door into the patient compartment of the vehicle for which the license or permit was issued. The information on the license or permit shall be readable from outside the vehicle.

8:40-2.11 Vehicle recognition number

In recognition of the need for the public to be able to identify specific vehicles licensed by the Department and to avoid confusion between firms with similar appearing names, each vehicle shall have a vehicle recognition number. The licensee shall, with the approval of the Department, permanently assign a unique non-duplicated one, two, three or four-digit Arabic number, or a combination of letters and Arabic numbers not to exceed four characters, to each vehicle.

8:40-2.12 Waiver

(a) (No change.)

(b) A licensee seeking a waiver of part(s) of this chapter shall apply in writing to:

Office of Emergency Medical Services
New Jersey State Department of Health
CN 364
Trenton, NJ 08625-0364

8:40-2.13 Non-transferability

No permit or license issued by the Department under this chapter is assignable or transferable. Any permit or license shall be immediately void if the ownership of the agency and/or vehicle changes.

8:40-2.14 Return of vehicle license

(a) The licensee shall return to the Department the vehicle license:

1. Concurrent with the surrender or termination of its provider license; or

2. When the vehicle is sold or becomes unusable.

8:40-2.15 Discontinuance of vehicle use

(a) In order to protect the public health, safety and welfare, an authorized representative of the Department is empowered to place an "Out-of-Service" notice on any vehicle licensed under this chapter when a survey has determined that the vehicle, equipment, or staffing poses an imminent threat to the health, safety or welfare of the public or to patients using the service.

(b) (No change.)

(c) The licensee shall immediately cease to utilize the vehicle to provide any services authorized under this chapter if an "Out-of-Service" notice is placed on the vehicle. The licensee shall ensure that the "Out-of-Service" notice is not removed from the vehicle, except as provided in (d) below. The licensee shall have the right to appeal to the Commissioner for a hearing concerning the placement of the "Out-of-Service" notice.

(d) An "Out-of-Service" notice shall only be removed by an authorized representative of the Department upon a finding that the applicable deficiencies have been corrected. Correction of deficiencies could include, but is not limited to:

1.-2. (No change.)

(e) The licensee shall notify the Office of Emergency Medical Services by telephone when it believes that a deficiency has been corrected. The Office of Emergency Medical Services will make arrangements to reinspect the vehicle in the field within five business days or at the Office of Emergency Medical Services within two business days. The "Out-of-Service" notice will only be removed upon a finding that the applicable deficiencies have been corrected, as in (d) above.

8:40-2.16 Action against a licensee

(a) Violation of any of the provisions of this chapter may result in action to impose a fine or to revoke the license of the provider. (See N.J.S.A. 26:2H-13 and 26:2H-14 for authority and maximum fines.)

Recodify existing (c)-(e) as (b)-(d) (No change in text.)

8:40-2.17 Hearings

Except as provided in N.J.A.C. 8:40-2.15, no permit or license shall be suspended or revoked and no fine shall be imposed without affording the licensee an opportunity for a hearing. In the event an Out-of-Service notice has been placed on the vehicle pursuant to N.J.A.C. 8:40-2.15, the hearing shall be held within 10 days unless an adjournment is requested by the licensee. The procedures governing all hearings shall be in accordance with the Administrative Procedure Act N.J.S.A. 52:14B-1 et seq. and N.J.S.A. 26:2H-1 et seq. and the Uniform Administrative Rules of Practice, N.J.A.C. 1:1.

SUBCHAPTER 3. GENERAL REQUIREMENTS

8:40-3.1 Agency ownership

(a) The ownership of the institution, agency or business concern applying for licensing and the ownership of the vehicle(s) shall be

disclosed to the Department. Proof of this ownership shall be made available to representatives of the Department.

(b) Any *[company]* ***corporation*** which proposes a redistribution of ***10 percent or more of its*** stock, ***or any individual owner, partnership, or proprietorship which proposes any redistribution of stock whatsoever, and any licensed agency which proposes*** a transfer of ownership or a change in the scope of its service must contact the Department to ascertain if Certificate of Need approval and/or new provider and vehicle permits will be needed before starting to provide service with the new name and/or new owners, and/or changing the type of service it provides.

(c) (No change in text.)

(d) No person who was a principal or owner in a company which was licensed under this chapter and which had its license revoked, following the opportunity for a hearing as provided under N.J.A.C. 8:40-2.17, shall be eligible to be a principal or owner of a subsequent service licensable under this chapter.

(e) (No change in text.)

8:40-3.2 Administrator required

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

(d) Either the licensee, the administrator, or an alternate shall be designated as principal contact and shall be available for consultation with the Department during business hours.

8:40-3.3 Standard operating procedures

(a) The licensee shall develop written standard operating procedures to ensure compliance with the requirements of this chapter.

(b) The procedures shall be contained in a manual which is readily available to all staff of the licensee.

(c) In addition to addressing the employees' responsibilities under this chapter, such as operating with surveys, the rules governing "out-of-service" vehicles, the possibility of incurring fines in case of licensure violations, having training credentials immediately available and performing duties in a professional manner, the manual should address sanitation requirements, vehicle cleanliness, communicable disease guidelines, placing patients into physical behavioral restraints, patients' rights and confidentiality, vehicle breakdowns and other areas of concern to the licensee or the Department. The manual shall also contain a nondiscrimination statement, outlining the service's willingness to transport and treat patients with AIDS. As appendices, the manual shall include a copy of the EMS Annex and the HAZMAT Annex of the State disaster plan, if the service provides "street EMS." A copy of these rules (N.J.A.C. 8:40) shall be included in the manual, but, by itself, is not sufficient to totally meet the requirements of this section.

8:40-3.4 Business locations

(a) (No change.)

(b) The Department shall also be informed of the location of any satellite offices and vehicle storage sites maintained by the licensee. The Department shall be notified at least 30 days prior to commencement of business at any proposed satellite location.

(c) The licensee may park or store its vehicles at location(s) not under the licensee's control (such as at employees' homes or upon public streets), consistent with local ordinances.

8:40-3.5 Report of unusual occurrences

(a) The licensee shall immediately notify the Department by telephone, followed by a written confirmation within 72 hours, of:

1. Any death or any injury requiring hospitalization or treatment in an emergency department, which occurred to patients ***while*** being transported by the licensee's Invalid Coach or Transport Ambulance.

2. Any injury requiring hospitalization or treatment in an emergency department, which occurred while a patient was being treated by the licensee's staff or transported by the licensee's Emergency Ambulance.

3. Any motor vehicle accident involving the licensee's vehicle which occurred on a public roadway ***and which resulted in death, hospitalization, or treatment in an emergency department***.

4. Any death, or any injury requiring hospitalization or treatment in an emergency department, which occurred to any on-duty personnel of the licensee.

5. Any fire on or within the licensee's vehicle(s) or business location(s) resulting in any damage to *[premises, vehicles, or]* records.

6. Any removal of a vehicle from service for a period greater than 30 days.

(b) (No change.)

8:40-3.6 Advertising restrictions

(a) (No change.)

(b) Any provider which responds to a bid to provide service must hold a Certificate of Need and a license which allows operation in that locale and at that level of service, unless the provider was already providing that level of service in that locale at the time N.J.A.C. 8:40 was initially adopted in 1985 and was "grandfathered" without a Certificate of Need.

Recodify existing (b)-(d) as (c)-(e) (No change in text.)

(f) The words "Paramedic," "Mobile Intensive Care," "Intensive Care," "MICU", "Critical Care Transport Unit", "CCTU", "Coronary Care" or "Special Care," or abbreviations of such words, shall only appear in advertisements when the provider is authorized to provide Mobile Intensive Care Unit Services in accordance with N.J.S.A. 26:2K-2 et seq. or has been granted a Certificate of Need for such services under N.J.A.C. 8:33N.

(g) (No change in text.)

8:40-3.7 Minimum personnel requirements

(a) Each person who operates a motor vehicle licensed under this chapter shall possess and have readily available for inspection a valid driver's license, as required under N.J.S.A. 39:3-10 (Title 39, Motor Vehicle and Traffic Regulations).

(b) Each person who staffs or operates a vehicle licensed under the chapter:

1. Shall be at least *[17]* ***18*** years old;

2. Shall dress in clothing, including any outerwear, ***of a similar uniform appearance*** which presents a professional appearance;

3. Shall wear the following identification:

i. His or her first and/or last name; and

ii. The name of the licensee.

4. (No change.)

5. Shall have readily available for inspection, either on his or her person or in the vehicle, valid documentation, or other proof thereof, of his or her training as may be required in this chapter.

(c) (No change.)

(d) ***Each person who staffs a vehicle licensed under this chapter may wear appropriate patches, pins or other items identifying training courses the person has completed. However, no*** *[No]* person shall be allowed to staff a vehicle licensed under this chapter while displaying any patch or other symbol indicating a level of training he or she has not attained or is not eligible to provide on that service.

(e) No person shall be allowed to staff or operate a vehicle licensed under this chapter:

1. While under the influence of intoxicating liquor or narcotic or habit forming drugs; or

2. In a reckless manner; or

3. At excessive speed; or

4. While engaging in any *[unprofessional or]* illegal conduct.

8:40-3.8 Personnel files required

A personnel file shall be maintained for each employee. The file shall include the employee's name, home address, documentation of training and expiration date of current training certification or licensure and a copy of the employee's current driver's license, if the employee is a licensed motor vehicle operator.

8:40-3.9 Maintenance of records

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

(c) The licensee shall retain and safely store all required medical records for at least 10 years ***, or until age 23 for patients treated as minors, whichever occurs later,*** and all other required records

for at least five years. In the event the licensee ceases operation for any reason, the licensee shall arrange for the safe storage of required records at a place, and in a manner, acceptable to the Department.

8:40-3.10 General vehicle requirements

(a) Motor vehicles licensed under this chapter shall be registered, maintained and operated in accordance with Title 39 Motor Vehicle and Traffic Regulations of the State of New Jersey.

(b) Vehicles registered as motor vehicles in New Jersey shall display a valid motor vehicle inspection decal issued by the New Jersey Division of Motor Vehicles. The vehicle shall only be used to provide service after it has successfully passed all motor vehicle tests conducted by the New Jersey Division of Motor Vehicles, or by an authorized Reinspection Station. No vehicle shall provide services under this chapter while it bears a "reject sticker" issued by the New Jersey Division of Motor Vehicles.

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

(e) The interior of the vehicle shall be designed for the safety of patients and staff and the patient compartment shall have the following safety and sanitary features:

1.-3. (No change.)

4. The floor shall have a flat, even, unbroken ***, impervious*** surface and be covered with a slip resistant material.

5. (No change.)

6. Any seats with underseat storage shall have a latch(es) which will hold the seat closed. Magnetic latches or friction latches are prohibited.

7. Any cabinet door, except a sliding door, shall have a positive latching mechanism which will hold the door securely closed and will prevent the contents of the cabinet from pushing the door open from the inside. Magnetic latches or friction latches are prohibited.

8. Any items (stored outside of closed cabinets) shall be stored in a crashworthy manner. Use of rubber "shock cords" and Velcro®-type closures are prohibited.

(f) Once a vehicle is licensed by the Department, there shall be no further changes to the vehicle's interior configuration.

8:40-3.11 Motor vehicle chassis, body and components

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

(c) Tires shall be appropriate for the Gross Vehicle Weight of the vehicle. Radial and non-radial tires shall not be "mixed" on the vehicle.

(d) The vehicle exhaust system shall discharge beyond the side(s) of the vehicle and away from fuel tank filler pipe(s) and away from door(s) to minimize the amount of fumes and contaminants entering the vehicle. The exhaust system shall be free of leaks.

(e)-(h) (No change.)

8:40-3.13 Restrictions on carbon monoxide concentrations

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

(c) The vehicle exterior, doors, windows and related gaskets shall be in good condition in order to limit the entrance of carbon monoxide and other toxic gases and fumes into the vehicle. ***Carbon monoxide shall not enter the vehicle at rates greater than 10 ppm above the general ambient carbon monoxide concentration.***

(d) The vehicle shall be tested for interior carbon monoxide, in a manner acceptable to the Department, whenever a situation arises in which carbon monoxide intrusion is suspected or as an optional part of an official Department inspection of the vehicle. ***This provision shall not apply to vehicles with diesel engines.***

8:40-3.14 Sanitation requirements

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

(d) When the vehicle has been utilized to transport a patient known or suspected to have a communicable disease, the vehicle shall be cleaned and all contact surfaces, equipment and blankets shall be disinfected prior to transportation of another patient, according to current guidelines of the Federal Centers for Disease Control, Atlanta, Georgia, as amended and supplemented, incorporated herein by reference.

(e)-(i) (No change.)

(j) Single use latex gloves shall be available for staff use. They should be properly maintained and stored and should be properly disposed of after use.

8:40-3.15 Required insurance coverage

(a) Each licensee shall maintain the required minimum insurance as outlined in (a)1 through 4 below plus such additional insurance as the licensee may deem necessary in order to be eligible to provide services under this chapter. The licensee shall discontinue any and all services licensed under this chapter in the event any portion of the required insurance is cancelled or becomes void.

1. The licensee shall have and maintain at least $500,000 per occurrence of combined bodily injury/property damage coverage for each vehicle licensed under this chapter; and

2. The licensee shall have and maintain at least $300,000 of single limit coverage of "premises and operations" type general liability insurance; and

3. The licensee shall have and maintain at least $300,000 per occurrence coverage of "malpractice" type professional liability insurance ***, if operating an ambulance service, or regular professional liability insurance, if operating an invalid coach service***; or

4. The general liability and malpractice ***or professional liability*** insurance required in (a)2 and 3 above may be combined in a single policy of at least $500,000 per occurrence.

(b) The licensee will be required to submit an official "certificate of insurance" form, covering all three types of insurance mentioned above and issued by the insurance carrier(s), at the time of initial licensure. This form or forms shall show that the required insurance has been purchased and is in force. If vehicles are insured as "scheduled autos" the Vehicle Identification Number (VIN) of each vehicle must be listed on the certificate of insurance. The trade name of the licensee must be listed as an insured.

(c) Upon application for relicensure, the licensee shall supply the Department with the following information as part of the relicensure form: name of the policyholder (which must include the licensee's tradename), name of the insurance company or companies issuing each policy, each applicable policy number, the expiration date of each policy, and the types and limits of coverage for each policy.

(d) Department staff may ask to see vehicle insurance cards during vehicle spot checks or to see copies of the service's insurance policies during inspection visits to the provider's place of business to verify that the required insurance is in force.

(e) *[Should the examined documents during spot checks or site visits or the information supplied during relicensing appear questionable as to whether the required insurance is in force,]* ***At the discretion of the Department,*** the licensee shall be required to have its insurance carrier(s) submit another official "Certificate of Insurance" to the Department.

8:40-3.16 Pneumatic testing required

(a) All respiratory equipment used to provide services licensed under this chapter shall be pneumatically tested at least every six months and, if required by the manufacturer, at more frequent intervals. At a minimum, the tests shall measure the:

1. Flow rate and vacuum pressure delivered by each aspirator required in N.J.A.C. 8:40-5.14 and 8:40-6.15.

2. Flow rate and inspiratory pressure delivered by each oxygen-powered resuscitator required in N.J.A.C. 8:40-5.13 and 8:40-6.14.

3. Flow rate, inspiratory pressure and deflating/refilling time cycles of each bag-valve-mask resuscitator required in N.J.A.C. 8:40-5.13 and 8:40-6.14.

4. Flow rate delivered by each oxygen flowmeter required in N.J.A.C. 8:40-5.12 and 8:40-6.13 and permitted in N.J.A.C. 8:40-4.9.

5. Pressure delivered by each oxygen system regulator required in N.J.A.C. 8:40-5.12 and 8:40-6.13 and permitted in N.J.A.C. 8:40-4.9.

(b) Periodic pneumatic testing may be conducted by staff of the licensee or by an outside agency. All tests shall be conducted in accordance with the Pneumatic Testing Guide as published by and from the Department.

(c) The results of the pneumatic test shall be kept on file at the licensee's principal place of business.

(d) At the discretion of the Department, pneumatic testing done by approved outside agencies may be accepted for the purpose of vehicle licensure.

8:40-3.17 Biomedical equipment testing required

(a) In recognition that licensees may provide biomedical patient care equipment for hospital staff to use, any biomedical patient care equipment used to provide services licensed under this chapter shall be inspected and tested every six months and, if required by the manufacturer, at more frequent intervals.

(b) For the purposes of this section, biomedical patient care equipment includes, but is not limited to:

1. Cardiac resuscitators (that is, Thumpers®);
2. Cardiac defibrillators and/or monitors;
3. Incubators;
4. Specialized respirators; and
5. Automatic ventilators.

(c)-(e) (No change.)

8:40-3.18 Physical behavioral restraints

(a) No patient shall be placed in, or transported in, physical behavioral restraints unless:

1. A physician or court has authorized the placement of the restraints;
2. The patient is in the custody of a law enforcement officer; or
3. The medical condition of the patient mandates transportation to, and treatment at, a health care facility, and the patient manifests such a degree of behavior that he or she:

i. Poses serious physical danger to himself or herself or to others; or

ii. Causes serious disruption to ongoing medical treatment which is necessary to sustain his or her life or to prevent disability.

(b) No patient shall be kept in physical behavioral restraints for a period greater than one hour unless:

1. A physician or court has authorized the use of the restraints for longer than one hour; or
2. The patient is accompanied in the rear of the vehicle by a law enforcement officer.

(c) No physical behavioral restraint shall be of a type, or used in a manner, that causes undue physical discomfort, harm or pain to a patient. Hard restraints, such as handcuffs, are specifically prohibited unless the patient is accompanied by the law enforcement officer who applied the hard restraints or handcuffs.

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

SUBCHAPTER 4. SPECIFIC INVALID COACH REQUIREMENTS

8:40-4.1 Patient restrictions

(a) Except as prohibited in (b) below, non-emergency health care transportation by Invalid Coach Vehicles shall be provided to patients who are under the supervision and care of a physician ***, or other recognized health care provider,*** and who:

1. Are ambulatory; or
2. Are wheelchair bound.

(b) Service shall not be provided to a patient who requires (based upon current medical condition or past medical history):

1.-4. (No change.)

5. An automatic ventilator or whose breathing is ventilator-assisted; or

Recodify existing 5.-8. as 6.-9. (No change in text.)

8:40-4.2 General vehicle requirements

(a) (No change.)

(b) Each vehicle used by a licensee to provide Invalid Coach Service shall have and display a valid Invalid Coach license issued by the Department.

8:40-4.3 Patient compartment requirements and dimensions

(a) (No change.)

*[(b) The patient compartment shall have the following minimum interior dimensions:

1. Height: At least 52 inches between the floor and ceiling when measured at, or near, the center of the patient compartment.

2. Width: At least 56 inches between the vehicle interior sides when measured at any point 42 inches above the floor. (The width of cabinets, etc. will be included when measurements are made.)

3. Length: At least 92 inches between the interior surface of the rear door and the rear of the driver's seat, or, if present, the surface of any partition, when measured at floor level.]*

***(b) Vehicles submitted for initial licensure after March 1, 1993, shall meet the following patient compartment dimensions:**

1. Height: At least 58 inches between the floor and the ceiling, when measured above each wheelchair restraint position.

2. Width: At least 56 inches between the vehicle interior sides when measured at any point 42 inches above the floor. (The width of cabinets, etc. will be included when measurements are made.)

3. Length: At least 92 inches between the interior surface of the rear door and the rear surface of the driver's seat or, if present, the surface of any bulkhead or partition, if three or four wheelchair positions are present. At least 82 inches between the interior surface of the rear door and the rear surface of the driver's seat or, if present, the surface of any bulkhead or partition, if one or two wheelchair positions are present.*

(c) The patient compartment shall have at least two exterior doorways:

1. (No change.)

2. Each doorway opening shall be at least 28 inches wide and at least *[44]* ***56*** inches high ***on vehicles licensed for the first time after March 1, 1993*.**

3. The wheelchair access to any doorway shall not be obstructed by any immovable objects, such as, but not limited to, bench seats, spare tires, and storage compartments, except as permitted in N.J.A.C. 8:40-4.4(a).

4. The door(s) to each patient compartment doorway shall be capable of being opened and being used from inside the patient compartment and from the exterior of the vehicle, using a standard automotive industry door handle.

5. (No change.)

***(d) Vehicles which do not meet the height requirements of (b) above, or the post-March 1, 1993, door opening requirements of (c) above, shall be eligible for "grandfather" licensing, if they meet these minimum requirements: Patient compartments must be at least 52 inches high when measured between the floor and the ceiling at, or near, the center of the patient compartment, vehicles must meet the width and length requirements of (b) above, and doorway openings must be at least 28 inches wide and at least 44 inches high. "Grandfather" licensing shall only apply to the provider of and for use as an invalid coach by that provider for the life of the vehicle, provided:**

1. The vehicle has continuously been licensed to the same provider for use as an invalid coach prior to March 1, 1993; or

2. The vehicle has been surveyed for the first time as an invalid coach to that provider prior to March 1, 1993; and

3. The vehicle continues to meet all criteria for licensure as an invalid coach, as listed in the balance for this subchapter; and

4. The vehicle is not out-of-service for more than three consecutive months; and

5. The vehicle is not sold or transferred to another owner. (Sale or transfer invalidates the vehicle's eligibility for continued licensure as a "grandfathered" invalid coach.)*

[(d)] ***(e)*** (No change in text.)

[(e)] ***(f)*** There shall be wheelchair restraint positions to secure and immobilize each occupied wheelchair transported in the vehicle.

1. Any wheelchair restraint system shall secure and immobilize the frame of the wheelchair in a crashworthy manner and so that movement of the occupied wheelchair does not exceed one inch in any direction. The restraint system shall not be attached to the wheels of the wheelchair.

***2. On vehicles licensed prior to March 1, 1993, rear wheellock (cam lock) wheelchair restraint systems will be allowed for the life of the vehicle, as long as it is continuously licensed to the same provider, as outlined in (d)1 through 5 above. The restraint system must meet all other requirements of this subsection.**

*[2.]***3.*** Each wheelchair shall have a patient seatbelt which secures the patient into the wheelchair in a configuration similar to an automotive lapbelt. Velcro® type closures are prohibited. The seatbelt shall attach only to the wheelchair, not to the vehicle, and shall not be part of the wheelchair restraint system.

8:40-4.4 Ramp or lift required

(a) There shall be a ramp, lift or other device for the safe exit/entry of occupied standard size wheelchairs. The device shall be permanently fastened to the vehicle and be capable of accommodating a load of at least 500 pounds. When in transit, the device shall be secured in a crashworthy manner and shall be positioned so as not to obstruct both of the required doorways.

(b) (No change.)

(c) Any device which relies on electric, hydraulic or other power for its operation shall be capable of manual operation by an unassisted person or there shall be a manually operated backup device. The manual backup device shall be capable of both lifting and lowering the patient and shall perform either function within five minutes.

8:50-4.5 Vehicle markings

(a) The trade name which appears on the license, issued by the Department, shall appear in a size not less than *[six]* ***four*** inches high on the two exterior sides of the vehicle, for any vehicle licensed after March 1, 1992***, for the first time***.

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

(d) Signs shall appear in the patient compartment which state "Smoking Prohibited."

(e) (No change.)

(f) To avoid the appearance of an emergency vehicle, the following shall not appear on the vehicle:

1. Symbol(s) consisting of or resembling the "Star of Life," a Greek cross or a Maltese cross, or any symbol implying provision of advanced life support.

2. Words, or abbreviations of words, such as "Emergency," "Emergency Medical Technician," "Paramedic," "Mobile Intensive Care," "Coronary Care", "Intensive Care," "Advanced," "Trauma," or "Critical."

(g) (No change.)

8:40-4.6 Emergency warning devices prohibited

No Invalid Coach vehicle shall be equipped with, or appear to be equipped with, audible or visible emergency vehicle warning devices, such as flashing or rotating lights, sirens or airhorns.

8:40-4.8 General equipment and supplies requirement

(a) (No change.)

(b) All equipment and supplies, including unoccupied wheelchairs, shall be stored in a safe, crashworthy manner, as outlined in N.J.A.C. 8:40-3.10(e).

8:40-4.9 Oxygen administration devices

(a) Oxygen administration devices may, but need not, be carried in the vehicle. If carried, the oxygen and related equipment shall comply with the requirements of this section and the vehicle shall be staffed in accordance with the requirements of N.J.A.C. 8:40-4.12(b).

(b) (No change.)

(c) Any portable oxygen system shall be capable of safely storing and supplying at least 300 liters of medical oxygen. Cylinder opening handles/wrenches shall be chained to the regulator or affixed to the cylinder. All oxygen storage arrangements shall comply with applicable provisions of Federal specification KKK-A-1822.

(d) (No change.)

(e) Any oxygen system shall have an oxygen flowmeter. The oxygen flowmeter shall have a gauge or dial with a range of at least 0 to 15 liters per minute (lpm) in calibrated increments. The flowmeter on any portable oxygen system shall be non-gravity dependent. Flowmeters shall be accurate to within one lpm when at a setting equal to or less than ***five lpm, 1.5 lpm when at a setting between six lpm and*** 10 lpm and within *[1.5]* ***two*** lpm when at a setting equal to or greater than 11 lpm. Non-dial type flowmeters must take at least one full turn to go from 0 to 15 lpm. Indicators on dial-type flowmeters must be securely seated at each flow rate position.

(f) If oxygen administration equipment is carried, there shall be at least three clear adult size simple inhalation masks of the single service type and two single service cannulas.

(g)-(h) (No change.)

8:40-4.10 Safety equipment

(a) The vehicle shall have the following minimum safety equipment:

1. Three portable red emergency reflective safety triangles, or three battery-operated flashers, or six flares;

2. One flashlight, two D cell size or larger; and

3. One or two fire extinguishers, U.L. rated at least 1A 10BC in total. The extinguisher(s) shall have either a gauge indicating it is fully charged, or a current inspection tag.

8:40-4.11 Required staff

While in service, each Invalid Coach vehicle shall be staffed by at least one person who shall meet the requirements of N.J.A.C. 8:40-3.7 and this subchapter. A second invalid coach staff member, also meeting the same requirements, shall be required ***at the time the patient is loaded or unloaded,*** if a patient in a wheelchair must be moved up or down five or more steps or if a patient in a wheelchair weighs 200 or more pounds ***and must be moved up or down two or more steps. The second staff member need not be present at other times.***

8:40-4.12 Required training of staff

(a) If oxygen administration devices are not carried in the vehicle, the required staff person(s) shall possess valid certification in Passenger Assistance Techniques (P.A.T.) issued by Transportation Management Associates, Ft. Worth, Texas, and one of the following:

1. BLS-A: Heartsaver, issued by the American Heart Association; or

2. Adult CPR, issued by the American National Red Cross.

(b) If oxygen administration devices are carried in the vehicle, the required staff person(s) shall possess valid certification as an Emergency Medical Technician-Ambulance, issued by the Department, in addition to the training required in (a) above.

8:40-4.13 Duties of staff

(a) The collective duties of each person who staffs an Invalid Coach vehicle shall include, but are not limited to:

1. Assisting patients to enter and to leave the vehicle, supervising the well being of patients while in the vehicle and ensuring the privacy, comfort, and appropriate care of patients;

2. Assuring that all wheelchairs are properly restrained in the required restraints and that all wheelchair patients are restrained in the wheelchair in accordance with N.J.A.C. 8:40-4.3(e)2;

3. Assuring that the driver and all other vehicle occupants wear automobile safety belts;

4. (No change in text.)

5. Reporting verbally to the appropriate personnel when a patient is brought to a health care facility or other place of medical care; and

6. Prohibiting smoking within the vehicle at all times.

8:40-4.14 Call report

(a) A call report approved by the Department shall be completed each time a patient is transported. One call report will suffice for both legs of a round trip. The call report, which may be combined with another report or form, shall contain the following information typed or printed in ink:

1. Patient's name and home address;

2. A description, including any observed changes, if the patient's condition worsens; and

3. Vehicle recognition number, full name(s) of driver and any other staff, and date.

8:40-4.15 Radio communications

(a) (No change.)

(b) Any radio communications shall comply with the radio frequency allocation cited in Table 4 of the JEMS Communications

Plan published by the Department or in the appropriate table of any future revision of the JEMS plan. The vehicle does not have to be equipped with a "JEMS radio." Specifically, the following radio frequencies shall not be used in radio communications to, or from, Invalid Coach vehicles:

1. Any of the UHF radio frequencies known as "Med 1" through "Med 10";

2. Any of the VHF radio frequencies listed in Appendix A of this chapter; and

3. Any of the following radio frequencies: 155.280 MHz, 155.340 MHz, 153.785 MHz.

(c) The provisions of (b) above shall not apply if:

1. The Federal Communications Commission determines that Invalid Coach vehicles are eligible to use "Special Emergency Radio Frequencies"; and

2. The provider was issued a Federal Communications Commission license before January 1, 1978 to use one (or more) of the cited frequencies; and

3. The provider is using that same frequency(ies); and

4. Use of that frequency(ies) does not cause harmful interference to other health care providers operating in accordance with the JEMS Plan.

(d) For the purpose of this section, harmful interference is defined as:

1. A written complaint alleging radio interference from a health care provider(s) operating in accordance with the JEMS Plan; and

2. A finding by the New Jersey Office of Frequency Coordination (or, if their services are not available, the Department) that the provider's radio operations are causing harmful interference.

SUBCHAPTER 5. SPECIFIC TRANSPORT AMBULANCE REQUIREMENTS

8:40-5.1 Restrictions on future licensing

(a) As of *[one year from the operative date of these amended rules]* ***March 1, 1993***, no transport ambulances, other than those which meet the criteria in (b) below, shall be licensed to any provider.

(b) Vehicles which meet the following criteria may continue to be licensed to the provider of record on *[(one year after the operative date of these amended rules)]* ***March 1, 1993*** as transport ambulances for the life of the vehicle:

1. The vehicle must possess valid licensure as a transport ambulance *[within one year from the operative date of these amended rules]* ***on or before March 1, 1993***;

2. The vehicle must continue to meet all criteria for licensure as a transport ambulance, as listed in the balance of this subchapter; and

3. The vehicle cannot be out-of-service for more than three consecutive months.

(c) Sale of the vehicle, or transfer to another owner, invalidates the vehicle's eligibility for continued licensure as a transport ambulance.

8:40-5.2 Patient restrictions

(a) Except as prohibited in (b) below, non-emergency health care transportation by Transport Ambulance vehicles shall be provided to patients who are under the supervision and care of a physician***, or other recognized health care provider,*** and who:

1. Are ambulatory; or

2. Are wheelchair bound; or

3. Require transportation in a prone or supine position or who are bed or stretcher bound; or

4. Require constant attendance due to a medical and/or mental condition.

(b) Service shall not be provided to a patient who requires (based upon current medical condition or past medical history):

1. Aspiration; or

2. Management or observation of intravenous fluids and/or intravenous medications; or

3. Emergency medical services or other emergency services, such as emergency inter-hospital transfer; or

4. Treatment in the Emergency Department of a hospital (for other than routine, non-emergency, follow-up care of a previously diagnosed and treated condition); or

5. Treatment in, or admission to:

i. The Obstetrical Unit (Labor and Delivery Suite) of a hospital; or

ii. The Intensive and/or Coronary Care Unit of a hospital; or

iii. The neonatal or newborn unit of a hospital.

6. If a patient suddenly and unexpectedly requires Emergency Department treatment after transportation has begun, that patient shall be transported to an Emergency Department of a hospital.

(c) The requirements in (a) and (b) above mean that nearly every trip to an acute care medical facility will be beyond the scope of this vehicle; however, if a patient suddenly and unexpectedly requires emergency department treatment after transportation has begun, that patient shall be transported to an emergency department of a hospital.

8:40-5.3 General vehicle requirements

(a) (No change.)

(b) Each vehicle used by the licensee to provide Transport Ambulance Service shall have and display a valid Transport Ambulance license, issued by the Department.

8:40-5.4 Patient compartment requirements

(a) (No change.)

(b) The patient compartment shall have at least two exterior doorways.

1.-2. (No change.)

3. The doorways shall not be obstructed except as permitted in N.J.A.C. 8:40-5.6(a).

4. The door(s) to each patient compartment doorway shall be capable of being opened and being used from inside the patient compartment and from the exterior of the vehicle, using a standard automotive industry door handle.

5. (No change.)

(c)-(e) (No change.)

(f) Occupied wheelchairs may, but need not, be transported in the vehicle. If transported in the vehicle, there shall be wheelchair restraint positions to secure and immobilize each occupied wheelchair.

1. Any wheelchair, restraint system shall secure and immobilize the frame of the wheelchair in a crashworthy manner and so that movement of the occupied wheelchair does not exceed one inch in any direction. The restraint system shall not be attached to the wheels of the wheelchair.

2. On vehicles licensed prior to March 1, 1993, rear wheellock (cam lock) wheelchair restraint systems will be allowed for the life of the vehicle, as long as it is continuously licensed to the same provider, as outlined in N.J.A.C. 8:40-5.1(b) (above). The restraint system must meet all other requirements of this subchapter.*

*[2.]***3.*** Each wheelchair shall have a patient seatbelt which secures the patient into the wheelchair in a configuration similar to an automotive lapbelt. Velcro® type closures are prohibited. The seatbelt shall attach only to the wheelchair, not to the vehicle, and shall not be part of the wheelchair restraint system.

(g) There shall be sufficient crashworthy cabinets and other storage spaces to safely accomodate all equipment and supplies, as per N.J.A.C. 8:40-3.10(e).

8:40-5.5 (No change in text.)

8:40-5.6 Ramp or lift

(a) There may, but need not, be a ramp, lift or other device for the safe exit/entry of occupied standard size wheelchairs. Any such device shall be permanently fastened to the vehicle and be capable of accommodating a load of at least 500 pounds. When in transit, the device shall be secured in a crashworthy manner and shall be positioned so as not to obstruct both of the required doorways.

(b) (No change.)

(c) Any device which relies on electric, hydraulic or other power for its operation shall be capable of manual operation by an unassisted person or there shall be a manually operated backup device. The

manual backup device shall be capable of both lifting and lowering the patient and shall perform either function within five minutes.

8:40-5.7 Vehicle markings

(a) The trade name which appears on the license, issued by the Department, shall appear in a size not less than *[six]* ***four*** inches high on the two exterior sides of the vehicle for any vehicle licensed after March 1, 1992, ***for the first time.***

(b) The vehicle recognition number shall appear in a size not less than three inches high on the rear and the two exterior sides of the vehicle.

(c) (No change.)

(d) A sign shall appear in the patient compartment which states: "Smoking Prohibited."

(e) (No change.)

(f) The following shall not appear on the vehicle:

1. Symbol(s) consisting of a:

i. "Star of Life"; or

ii. Greek Cross, unless the vehicle is operated by or associated with a volunteer first aid or rescue squad; or

iii. Maltese Cross, unless the vehicle is operated by a Fire Department.

2. The following words, or abbreviations of such words: "Coronary Care," "Special Care," "Intensive Care," "Mobile Intensive Care," or "Paramedic," or any other wording which would imply the provision of advanced life support.

(g) (No change.)

(h) The word "ambulance," or an abbreviation of the word, may only appear when:

1. It is accompanied by the word "Transport" and appears as "Transport Ambulance"; or

2. It is part of the lawful incorporated name of the licensee and the words "Transport Ambulance" appear on the vehicle in letters the same size as the word "Ambulance."

(i) (No change.)

8:40-5.8 Emergency warning devices

(a) The vehicle shall be equipped with:

1. Emergency warning lights which provide 360 degrees of visibility during emergency calls and which comply with applicable portions of the emergency lighting standards promulgated by the New Jersey Division of Motor Vehicles at N.J.A.C. 13:24; and

2. An emergency warning siren.

(b) Warning lights or audible signals which are not specifically approved by the Division of Motor Vehicles for use on New Jersey registered emergency vehicles shall not be used.

8:40-5.9 Use of emergency warning devices

(a) Emergency Warning Devices ("lights and/or siren") shall only be utilized in providing prehospital service when:

1. (No change.)

2. Transporting a patient and:

i. The patient's condition, suddenly and unexpectedly, worsens to constitute a medical emergency; and

ii. The use of emergency warning devices is necessary to expedite travel to a hospital in the judgment of the staff person caring for the patient, provided that the use of emergency warning lights and/or siren does not contribute to a worsening of the patient's condition.

8:40-5.10 General equipment and supplies requirement

(a) When in-service, the vehicle shall be equipped with all the required equipment and supplies at the start of each work shift. Expended supplies and/or damaged equipment shall be replaced whenever the vehicle is returned to its normal storage location. Equipment may be temporarily left on/with a patient, when medically necessary. This equipment must be replaced as soon as the vehicle returns to the location where backup equipment is stored. A record shall be made on the call report (required in N.J.A.C. 8:40-5.25) of any equipment left on/with a patient for followup and equipment retrieval purposes.

(b) All equipment and supplies shall be stored within the vehicle in a safe, crashworthy manner, as outlined in N.J.A.C. 8:40-3.10(e). Supplies which are stored shall be clearly visible through the door of the cabinet, or a list of contents shall appear on the door of any interior storage compartment which does not have "see through" doors.

8:40-5.11 Standard patient transport devices

(a) There shall be a wheeled litter for the transport of stretcher bound patients. The litter shall be at least 72 inches long (when flat) and at least 20 inches wide. The litter shall have a mattress at least two inches thick. The litter and mattress shall be adjustable from a flat to a semi-sitting position. The litter shall be adjustable from a minimum height of nine to 18 inches to a maximum height of 33 to 40 inches (measured to the top of the mattress). There shall be a pillow, pillowcase and sheet on the litter.

(b) (No change.)

(c) There shall be a portable stairchair for the safe transport of patients up and down flights of stairs. A combination stretcher/stairchair device will meet the requirements of both (b) above and this subsection.

(d) Each litter and portable stretcher shall have three sets of two inch wide patient restraints with quick release buckles (positioned at the chest, waist and knees.) The quick release buckles may be of the "slide through" or "metal to metal" type. ("Reeves" type stretchers may have other types of buckles.) Each stairchair shall have two sets of two-inch wide safety restraints with quick release metal buckles. Velcro®-type closures are prohibited.

(e) Any children, age five or under, who are transported as patients must be properly restrained in a Federally-approved child restraint system specifically designed for ambulance use, such as the Carrie® Life Seat™ (provided the child does not have spinal injuries), or on the ambulance stretcher. When not in use, the child restraint system may be, but need not be, stored on the vehicle. If not stored on the vehicle, the system must be immediately accessible on the provider's premises.

(f) (No change in text.)

8:40-5.12 Oxygen administration devices

(a) (No change.)

(b) There shall be a portable oxygen system capable of safely storing and supplying at least 300 liters of medical oxygen. Cylinder handles/wrenches shall be chained to the regulator or affixed to the cylinder. All oxygen storage arrangements shall comply with applicable provisions of Federal specification KKK-A-1822. There shall be at least one spare cylinder of at least 300-liter capacity.

(c) (No change.)

(d) Each required oxygen system shall have an oxygen flowmeter. Each oxygen flowmeter shall have a gauge or dial with a range of at least 0 to 15 liters per minute (lpm) in calibrated increments. The flowmeter on the portable oxygen system shall be non-gravity dependent. Flowmeters shall be accurate to within one lpm when at a setting equal to or less than ***five 1pm, 1.5 1pm when at a setting between six 1pm and*** 10 lpm and within *[1.5]* ***two*** lpm when at a setting equal to or greater than 11 lpm. Non-dial-type flowmeters must take at least one full turn to go from 0 to 15 lpm. Indicators on dial-type flowmeters must be securely seated at each flow rate position.

(e) There shall be four clear simple inhalation masks (two each in adult and child sizes) of the single service semi-open, non-rebreathing type and two single service type cannulas.

(f)-(g) (No change.)

8:40-5.13 Resuscitation devices

(a) The vehicle shall be equipped with an oxygen-powered resuscitator or with an adult size bag-valve-mask resuscitator. Carrying child-size or infant-size bag-valve-mask units is optional.

(b) Any oxygen-powered resuscitator shall provide:

1. 100 percent oxygen;

2. An instantaneous flow rate between 35 and 45 liters per minute;

3. Inspiratory pressure between 55 to 65 cm water pressure; and

4. 15/22 mm fittings.

(c) Any bag-valve-mask resuscitator shall meet the following criteria:

1. Have a self-refilling bag without sponge rubber inside;

2. Any adult-size bags shall be capable of deflating/refilling at least 20 times per minute at room temperature. Any child-size bags shall be capable of deflating/refilling at least 30 times per minute at room temperature. Any infant-size bag(s) shall be capable of deflating/refilling at least 40 times per minute at room temperature;

3. Valve shall be a true non-rebreathing valve and have 15/22 mm fittings.

(d) There shall be at least two transparent domed resuscitation face masks (one each in adult and child size) with 22 mm fittings.

(e) (No change.)

8:40-5.14 Aspirator/suction devices

(a) There shall be an installed aspirator (installed suction unit) powered by the vehicle's electrical system. The device shall be securely mounted and located to permit aspiration of a stretcher bound patient. The device shall meet the criteria contained in (b) below during the entire normal range of vehicle operation.

(b) Any suction device shall provide:

1. A flow rate of at least 30 liters per minute at the end of the suction tube; and

2. (No change.)

(c) Any suction device shall be equipped with a non-breakable collection bottle and at least three feet of transparent or translucent non-collapsible suction tubing with an interior bore of at least one quarter inch. (Three-eights of an inch bore is recommended.) There shall be one semi-rigid pharyngeal suction adapter and at least eight suction catheters in not less than four assorted adult and child sizes.

(d) Any portable suction device (optional) must meet the standards in (c) above, be powered by an integral battery, and meet the criteria in (b) above for at least 20 minutes.

(e) No suction device shall be carried in the vehicle unless it is suitable for use by an Emergency Medical Technician and meets the criteria contained in (b) above.

8:40-5.15 Airway maintenance supplies

(a) There shall be at least the following airway maintenance supplies:

1. Two bite sticks single service type; and

2. At least one airway kit containing seven or more different sized airways.

8:40-5.16 External cardiac compression support

A short spine board or a specially designed rigid board (such as a "CPR Board"®) shall be immediately available within the patient compartment. It shall not be stored under the benchseat.

8:40-5.17 Spine boards

(a) The following spine boards shall be carried in the vehicle:

1. One long spine board made of wood at least three-quarters of an inch thick, or of equivalent inflexible material, 72 inches long by 18 inches wide with associated strap holes and full length three quarter inch runners, or another configuration which protects the staff's hands from injury during patient movement; and

2. Three straps, two inches wide by nine feet long with quick release type metal buckles. Velcro®-type closures are prohibited.

8:40-5.18 Wound dressing and burn treatment supplies

(a) The following wound dressing and burn treatment supplies shall be carried in the vehicle:

1. Six conforming roller bandages, at least three inches wide;

2. Twelve triangular bandages (cravats) measuring 36 inches by 36 inches by 51 inches when unfolded;

3. Two sterile, individually packed universal (or multi trauma) dressings measuring at least nine inches by 30 inches when unfolded;

4. Twelve sterile, individually packed gauze pads at least four inches by four inches;

5. One roll adhesive type tape;

6. Two sterile, individually packed occlusive dressings or one sterile roll of aluminum foil;

7. One sterile, individually wrapped burn sheet, or other burn care product approved by the Commissioner; and

8. One liter sterile saline solution in a plastic container(s) (for flushing injury sites). Saline solution shall be current (not expired).

8:40-5.19 Poison treatment supplies

(a) The following poison treatment supplies shall be carried in the vehicle:

1. Four liquid ounces of Syrup of Ipecac; and

2. Four, three- to four-ounce bottles prepackaged liquid activated charcoal.

8:40-5.20 Other patient care equipment.

(a) There shall be the following other minimum patient care equipment:

1. Diaphragm type stethoscope;

2. Aneroid type blood pressure manometer and adult size cuff (an additional cuff in a child size is optional);

3. Glucose in form easily ingested by mouth (four sugar packets or one fluid ounce);

4. Four cloth blankets at least 60 inches by 80 inches in size from September 15 to May 1 and two blankets the rest of the year;

5. Two penlights suitable for patient examination;

6. Twelve pairs surgeon's type ***latex*** gloves; and

7. Two sets of personnel protection isolation garments, including gowns and masks.

(b) (No change.)

8:40-5.21 Safety equipment

(a) The vehicle shall have the following minimum safety equipment:

1. Three portable red emergency reflective safety triangles or three battery-operated flashers, or six flares;

2. One flashlight, two D cell size or larger; and

3. One or two fire extinguisher(s) U.L. rated at least 1A 10BC in total. The fire extinguisher(s) shall have either a gauge indicating it is fully charged or a current inspection tag.

8:40-5.22 Required staff

(a) When in-service, including any time the vehicle is used as an invalid coach, each Transport Ambulance shall be staffed by at least two persons who shall meet the requirements of N.J.A.C. 8:40-3.7 and this subchapter. All additional staff persons of the licensee shall meet the requirements of N.J.A.C. 8:40-3.7.

(b) (No change.)

8:40-5.23 Required training of staff

(a) Each of the required staff persons shall possess current valid certification as an Emergency Medical Technician-Ambulance, issued by the Department.

(b) Each of the required Emergency Medical Technicians-Ambulance shall possess valid current certification in cardiopulmonary resuscitation (CPR) for emergency services personnel issued by the American Heart Association (BLS-C: CPR for Healthcare Providers) or the equivalent American Red Cross course.

8:40-5.24 Duties of staff

(a) The collective duties of the persons who staff a Transport Ambulance vehicle shall include, but are not limited to:

1. Providing prompt, efficient and effective emergency medical care to the patient(s);

2.-3. (No change.)

4. Assuring that any stretcher, wheelchair or other patient transport device is safely and properly restrained, patients are restrained and all vehicle occupants wear automotive safety belts. *[Any child passengers must be properly restrained in a Federally-approved child safety seat.]* All wheelchair patients must be properly restrained in the wheelchair in accordance with N.J.A.C. 8:40-5.4(f)1 and 2. The staff person(s) caring for the patient need not wear a safety belt when providing essential life support such as CPR;

5.-7. (No change.)

8. Prohibiting smoking within the vehicle at all times; and

9. Entering data into and signing the required call report, when applicable.

8:40-5.25 Call report

(a) A call report approved by the Department shall be completed each time a patient is transported. The call report need not be

prepared by the staff assigned to the vehicle. The call report, which may be combined with another report or form, shall contain the following information typed or printed in ink:

1. The patient's name, age, sex and home address;
2. A description of the patient's condition and any observed changes;
3. A description of any care given to the patient;
4. The time when, and location where, patient was picked up and was discharged;
5. The vehicle recognition number, date, and full names of staff;
6. Whether or not emergency warning devices were used at the scene or in transit to the medical facility; and
7. Any required equipment left on/with a patient.

8:40-5.26 Radio communications

(a) (No change.)

(b) Any radio communications shall comply with the radio frequency allocation cited in Table 4 of the JEMS Communications Plan published by the Department or the appropriate table in any future revision of the JEMS plan. (The vehicle does not have to be equipped with a "JEMS radio.") Specifically, the following radio frequencies shall not be used in radio communications to, or from, Transport Ambulance vehicles:

1. Any of the UHF radio frequencies known as "Med 1" through "Med 10;"
2. Any of the VHF radio frequencies listed in Appendix A of this chapter; and
3. Any of the following radio frequencies: 155.280 MHz, 155.340 MHz, 153.785 MHz.

(c) The provisions of (b) above shall not apply if:

1. The provider was issued a Federal Communications Commission license before January 1, 1978 to use one (or more) of the cited frequencies; and
2. The provider using that same frequency(ies); and
3. Use of that frequency(ies) does not cause harmful interference to other health care providers operating in accordance with the JEMS Plan.

(d) For the purpose of this section, harmful interference is defined as:

1. A written complaint alleging radio interference from a health care provider(s) operating in accordance with the JEMS Plan; and
2. A finding by the New Jersey Office of Frequency Coordination (or, if their services are not available, the Department) that the provider's radio operations are causing harmful interference.

SUBCHAPTER 6. SPECIFIC EMERGENCY AMBULANCE REQUIREMENTS

8:40-6.1 Patient restrictions

(a) Emergency medical care and transportation shall be provided to a patient who:

1. Requires, or may require, pre-hospital emergency medical services; or
2. Requires, or may require, emergency inter-hospital transfer.

(b) Health care transportation may be provided to patients who are under the supervision and care of a physician**, or other recognized health care provider,*** and who:

1. Are ambulatory; or
2. Are wheelchair bound; or
3. Are bed or stretcher bound or who require transportation in a prone or supine position; or
4. Require constant attendance due to a medical and/or mental condition.

8:40-6.2 General vehicle requirements

(a) (No change.)

(b) Each vehicle used by the licensee to provide Emergency Ambulance Service shall have and display a valid Emergency Ambulance license, issued by the Department.

8:40-6.3 Patient compartment requirements

(a) (No change.)

(b) The patient compartment shall have at least two exterior doorways:

1.-3. (No change.)

4. The door(s) to each patient compartment doorway shall be capable of being opened and being used from inside the patient compartment and from the exterior of the vehicle, using a standard automotive industry door handle; and

5. (No change.)

(c)-(e) (No change.)

(f) Occupied wheelchairs may, but need not, be transported in the vehicle. If transported in the vehicle, there shall be wheelchair restraint positions to secure and immobilize each occupied wheelchair.

1. Any wheelchair restraint system shall secure and immobilize the frame of the wheelchair in a crashworthy manner and so that movement of the occupied wheelchair does not exceed one inch in any direction. The restraint system shall not be attached to the wheels of the wheelchair.

2. On vehicles licensed prior to March 1, 1993, rear wheellock (cam lock) wheelchair restraint systems will be allowed for the life of the vehicle, as long as it is continuously licensed to the same provider. The restraint system must meet all other requirements of this subchapter.

[2.] ***3.*** Each wheelchair shall have a patient seatbelt which secures the patient into the wheelchair in a configuration similar to an automotive lapbelt. Velcro®-type closures are prohibited. The seatbelt shall attach only to the wheelchair, not to the vehicle, and shall not be part of the wheelchair restraint system.

(g) There shall be sufficient crashworthy cabinets and other storage spaces to safely accommodate all equipment and supplies, as per N.J.A.C. 8:40-3.10(e).

8:40-6.4 Patient compartment dimensions

(a) Vehicles with the following minimum patient compartment dimensions shall be eligible for licensing and use as an ambulance as long as they comply with this chapter.

1.-3. (No change.)

8:40-6.5 Certification to Federal specifications

(a) Any vehicle presented for licensure shall be certified to meet the version of Federal Specification KKK-A-1822 which was current at the time the vehicle was manufactured for use as an emergency ambulance. The certification shall be made by the vehicle manufacturer or converter in accordance with applicable paragraphs of the Federal KKK-A-1822 specifications.

(b) The following exceptions to the Federal KKK-A-1822 specifications are permitted. Inclusions of these items on a New Jersey licensed emergency ambulance is optional:

1. Spare Tire and Storage;
2. Tools (tire changing);
3. 115 volt AC utility power;
4. Utility power connector;
5. Electrical 115 volt VAC receptacles;
6. Solid state inverter;
7. Spotlight;
8. Exterior storage accommodation;
9. Extrication equipment and storage;
10. Color, Paint and Finish;
11. Color standards and tolerances;

(c) The following exceptions to the Federal KKK-A-1822 specifications are permitted, within the parameters noted:

1. Ambulance emergency lighting. The licensee may specify emergency lights other than those required in the Federal specifications, but all exterior lighting must be in accordance with standards contained in the New Jersey motor vehicle regulations, N.J.A.C. 13:24;

2. Interior storage accommodations. A trash receptacle is optional. All other items are required;

3. Suction aspirators. The installed and portable aspirators (suction units) shall provide a free airflow of 30 lpm (rather than the 20 lpm specified in KKK-A-1822); and

4. Emblems and markings. The purchaser of the vehicle may specify the location of any additional lettering and markings which may be desired, beyond those required under the federal specifications.

8:40-6.6 Ramp or lift

(a) There may, but need not, be a ramp, lift or other device for the safe exit/entry of occupied standard size wheelchairs. Any such device shall be permanently fastened to the vehicle and be capable of accommodating a load of at least 500 pounds. When in transit, the device shall be secured in a crashworthy manner and shall be positioned so as not to obstruct both of the required doorways.

(b) (No change.)

(c) Any device which relies on electric, hydraulic or other power for its operation shall be capable of manual operation by an unassisted person or there shall be a manually operated backup device. The manual backup device shall be capable of both lifting and lowering the patient and shall perform either function within five minutes.

8:40-6.7 Vehicle markings

(a) The trade name which appears on the license, issued by the Department, shall appear in a size not less than *[six]* ***four*** inches high on the two exterior sides of the vehicle for any vehicle licensed after March 1, 1992, ***for the first time.***

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

(d) A sign shall appear in the patient compartment which states: "Smoking Prohibited."

(e) (No change.)

(f) The following shall not appear on the vehicle:

1. Symbol(s) consisting of a:

i. Greek Cross, unless the vehicle is operated by or associated with a volunteer first aid or rescue squad; or

ii. Maltese Cross, unless the vehicle is operated by a Fire Department.

2. The following words, or abbreviations of such words: "Coronary Care," "Special Care" or "Intensive Care," "Mobile Intensive Care," or "Paramedic," or any other wording which would imply the provision of advanced life support, unless the service qualifies under (g) below.

(g) The words "Paramedic" or "Mobile Intensive Care," or abbreviations of such words, shall only appear when the licensee is authorized to provide Mobile Intensive Care Unit Service in accordance with N.J.S.A. 26:2K-7 et seq.

(h) (No change.)

8:40-6.8 Emergency warning devices

(a) The vehicle shall be equipped with:

1. Emergency warning lights which provide 360 degrees of visibility during emergency calls and which comply with applicable portions of the emergency lighting standards promulgated by the New Jersey Division of Motor Vehicles in N.J.A.C. 13:24; and

2. An emergency warning siren.

(b) Warning lights or audible signals which are not specifically approved by the Division of Motor Vehicles for uses on New Jersey registered emergency vehicles shall not be used.

8:40-6.9 Use of emergency warning devices

(a) Emergency Warning Devices ("lights and/or siren") shall only be utilized in providing pre-hospital service when:

1. Responding to the location of a patient and:

i. There are reasonable grounds to believe that the patient's condition is serious enough to constitute a medical emergency; and

ii. The use of emergency warning devices is necessary to expedite travel to the patient's location;

2. At the scene of the call, and the use of emergency warning lights is necessary for safety reasons;

3. Transporting a patient to a hospital; and

i. The patient's condition is serious enough to constitute a medical emergency; and

ii. The use of emergency warning devices is necessary to expedite travel to the receiving hospital in the judgment of the staff person caring for the patient, provided that the use of emergency warning lights and/or siren does not contribute to a worsening of the patient's condition.

(b) Emergency Warning Devices ("lights and/or siren") shall only be utilized in providing inter-hospital transfer when:

1. Responding to the "sending" hospital, and

i. The "sending" or "receiving" physician, or his/her designee, clearly states that "emergency response" to the hospital is necessary; and

ii. The use of emergency warning devices is necessary to expedite travel to the "sending" hospital;

2. Transporting a patient to the "receiving" hospital, and

i. The "sending" or "receiving" physician, or his/her designee, clearly states that "emergency transportation" to the "receiving" hospital is necessary; and

ii. The use of emergency warning devices is necessary to expedite travel to the "receiving" hospital;

3. Transporting a patient to another hospital and:

i. The patient's condition, suddenly and unexpectedly, worsens to constitute a medical emergency; and

ii. The use of emergency warning devices is necessary to expedite travel to a hospital in the judgment of the staff person caring for the patient, provided that the use of emergency warning lights and/or siren does not contribute to a worsening of the patient's condition.

8:40-6.10 General equipment and supplies requirements

(a) When in-service, the vehicle shall be equipped with all the required equipment and supplies at the start of each work shift. Expended supplies and/or damaged equipment shall be replaced whenever the vehicle is returned to its normal storage location. Equipment may be temporarily left on/with a patient, when medically necessary. This equipment must be replaced as soon as the vehicle returns to the location where backup equipment is stored. A record shall be made on the call report (see N.J.A.C. 8:40-6.29) of any equipment left on/with a patient for followup and equipment retrieval purposes.

(b) All equipment and supplies shall be stored within the vehicle in a safe, crashworthy manner, as outlined in N.J.A.C. 8:40-3.10(e). Supplies which are stored shall be clearly visible through the door of the cabinet, or a list of contents shall appear on the door of any interior storage compartment which does not have "see through" doors.

8:40-6.11 Standard patient transport devices

(a) There shall be a wheeled litter for the transport of stretcher bound patients. The litter shall be at least 72 inches long (when flat) and at least 20 inches wide. The litter shall have a mattress at least two inches thick. The litter and mattress shall be adjustable from a flat to a semi-sitting position. The litter shall be adjustable from a minium height of nine to 18 inches to a maximum height of 33 to 40 inches measured to the top of the mattress. There shall be a pillow, pillowcase and sheet on the litter.

(b) (No change.)

(c) There shall be a portable stairchair for the safe transport of patients up and down flights of stairs. A combination stretcher/stairchair device will meet the requirements of both (b) above and this subsection.

(d) Each litter and portable stretcher shall have three sets of two-inch wide patient restraints with quick release buckles positioned at the chest, waist and knees. The quick release buckles may be of the "slide through" or "metal to metal" type. ("Reeves" type stretchers may have other types of buckles.) Each stairchair shall have two sets of two-inch wide safety restraints with quick release metal buckles. Velcro®-type closures are prohibited.

(e) Any children, age five or under, who are transported as patients must be properly restrained in a Federally-approved child restraint system specifically designed for ambulance use, such as the Carrie® Life Seat™ (provided the child does not have spinal injuries), or on the ambulance stretcher. When not in use, the child restraint system may be, but need not be, stored on the vehicle. If not stored on the vehicle, the system must be immediately accessible on the provider's premises.

(f) (No change in text.)

8:40-6.13 Oxygen administration devices

(a) (No change.)

(b) There shall be a portable oxygen system capable of safely storing and supplying at least 300 liters of medical oxygen. Cylinder handles/wrenches shall be chained to the regulator or affixed to the cylinder. All oxygen storage arrangements shall comply with applicable provisions of Federal specification KKK-A-1822. There shall be at least one spare cylinder of at least 300-liter capacity.

(c) (No change.)

(d) Each required oxygen system shall have an oxygen flowmeter. Each oxygen flowmeter shall have a gauge or dial with a range of at least 0 to 15 liters per minute in calibrated increments. The flowmeter on the portable oxygen system shall be non-gravity dependent. Flowmeters shall be accurate to within one lpm when at a setting equal to or less than ***five 1pm, 1.5 1pm when at a setting between six 1pm and*** 10 lpm and within *[1.5]* ***two*** lpm when at a setting equal to or greater than 11 lpm. Non-dial-type flowmeters must take at least one full turn to go from 0 to 15 lpm. Indicators on dial-type flowmeters must be securely seated at each flow rate position.

(e) There shall be at least four clear inhalation masks (two each in adult and child sizes) of the single service, semi-open, non-rebreathing type and two single service type cannulas.

(f) (No change.)

(g) Each oxygen cylinder shall:

1. Contain only medical grade oxygen;
2. Be color coded green;
3. Have a current hydrostatic test date; and
4. Be tagged (Full, In Use, Empty).

8:40-6.14 Resuscitation devices

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

(c) The vehicle shall be equipped with an adult size, a child size, and an infant size bag-valve-mask resuscitator.

(d) Any oxygen-powered resuscitator shall provide:

1. 100 percent oxygen;
2. An instantaneous flow rate between 35 and 45 liters per minute;
3. Temporary pressure between 55 and 65 on water pressure; and
4. 15/22mm fittings.

(e) Any bag-valve-mask resuscitator shall meet the following criteria:

1. Have a self-refilling bag without sponge rubber inside;
2. Adult size bags shall be capable of deflating/refilling at least 20 times per minute at room temperature. Child-size bags shall be capable of deflating/refilling at least 30 times per minute at room temperature. Infant size bag(s) shall be capable of deflating/refilling at least 40 times per minute at room temperature; and
3. Valve shall be a true non-rebreathing valve and have 15/22-mm fittings.

(f) There shall be at least six resuscitation face masks:

1. At least three transparent domed resuscitation face masks (one each in large adult, medium adult and child size) with 22mm fittings for the required oxygen-powered resuscitators;
2. Two transparent domed resuscitation face masks (one each in large adult and medium adult size) with 22mm fittings for the required adult size bag-valve-mask resuscitator; and
3. One transparent domed infant size mask with 22mm fittings for the required infant sized bag-valve-mask resuscitator.

(g) No resuscitation device shall be carried in the vehicle unless it:

1. Is suitable for use by an Emergency Medical Technician and meets the criteria in (d) and/or (e) above; or
2. Is prescribed by a physician for a patient being transported and is operated by a physician, nurse, respiratory therapist or inhalation therapist.

8:40-6.15 Aspirator/suction devices

(a) There shall be an installed aspirator (installed suction unit) powered by the vehicle's electrical system. The device shall be securely mounted and located to permit aspiration of a stretcher bound patient. The device shall meet the criteria contained in (c) below during the entire normal range of vehicle operation.

(b) There shall be a portable aspirator (portable suction unit) powered by an integral battery or by gas, such as oxygen. (Battery powered is recommended.) The device shall meet the criteria contained in (c) below for at least 20 minutes.

(c) Any suction device shall provide:

1. A flow rate of at least 30 liters per minute at the end of the suction tube; and
2. A vaccuum pressure of at least 300 mm mercury suction within four seconds and a maximum vacuum pressure of at least 400 mm.

(d) Each suction device shall be equipped with a non-breakable collection bottle, and at least three feet of transparent or translucent non-collapsible suction tubing with an interior bore of at least one quarter inch. Three-eighths of an inch bore is recommended. There shall be one semi-rigid pharyngeal suction adapter and at least eight suction catheters for each device in not less than four assorted adult and child sizes. At least one catheter shall be a size 8 and one shall be a size 18. An infant bulb syringe and one wide-bore, semi-rigid suction tip shall also be carried.

(e) No suction device shall be carried in the vehicle unless it:

1. Is suitable for use by an Emergency Medical Technician and meets the criteria contained in (c) above or in N.J.A.C. 8:40-6.20(a)4; or
2. Is prescribed by a physician for a patient being transported and is operated by a physician, nurse, respiratory therapist or inhalation therapist.

8:40-6.16 Airway maintenance supplies

(a) There shall be at least the following airway maintenance supplies:

1. Two bite sticks, single-service type; and
2. Fourteen airways in at least four different adult and child sizes.

8:40-6.17 External cardiac compression support

A short spine board or a specially designed rigid board (such as a "CPR Board"®) shall be immediately available within the patient compartment. It shall not be stored under the benchseat.

8:40-6.18 Spine boards, orthopedic litter and splints

(a) The following spine boards, orthopedic litter and splints shall be carried in the vehicle:

1. One long spine board made of wood at least three quarters of an inch thick, or of equivalent inflexible material, 72 inches long by 18 inches wide with associated strap holes and full length three-quarter inch runners, or another configuration which protects the staff's hands from injury during patient movement;
2. One short spine board made of wood at least one half of an inch thick, or of equivalent material, measuring 32 inches to 34 inches high. Body section 16 to 18 inches wide by 20 inches to 22 inches high with associated strap holes. Another commercially available spinal immobilization device (for example, K.E.D.®), approved by the Commissioner, may be substituted;
3. Four straps, two inches wide by nine feet long with quick release type metal buckles. ("Slide-through" type strongly recommended.) Velcro®-type closures are prohibited;
4. One orthopedic litter at least 78 inches long (when extended) by at least 16 inches wide. It shall open/close (separate/rejoin) along its long axis into two halves, and be fitted with three sets of two-inch wide restraining straps with quick release (slide through or metal to metal type) metal buckles. Velcro®-type closures are prohibited;
5. Six rigid cervical collars of a type approved by the Commissioner (for example, StifNeck® or Philadelphia-type) in at least three different sizes;
6. One head restraint system, used to immobilize a patient's head while the patient is restrained on a backboard, of a type approved by the Commissioner. Sandbags are prohibited;
7. A minimum of six splinting devices, of the types approved by the Commissioner (for example, padded board splints, selected commercial fracture products), in a variety of sizes suitable for splinting arms and/or legs; and
8. One adult size, lower extremity traction splint, either half-ring or padded ischial support type, complete with all associated straps,

heel stand windlass, and accessories, or other devices approved by the Commissioner.

8:40-6.19 Wound dressing and burn treatment supplies

(a) The following wound dressing and burn treatment supplies shall be carried in the vehicle:

1. Twelve conforming roller bandages, at least three inches wide by five yards long;

2. Twelve triangular bandages (cravats) measuring 36 inches by 36 inches by 51 inches when unfolded *[. Vehicles with wooden short spine boards should carry 24 triangular bandages]*;

3. Six sterile, individually packed universal (or multi-trauma) dressings measuring at least nine inches by 30 inches when unfolded;

4. Twenty-four sterile, individually packed gauze pads at least four inches by four inches;

5. Two rolls adhesive type tape;

6. Four sterile, individually packed occlusive dressings or one sterilized roll of aluminum foil;

7. Two sterile, individually wrapped burn sheets, or other burn care products approved by the Commissioner; and

8. Two liters sterile saline solution in a plastic container(s) (for flushing injury sites). Saline solution shall be current (not expired).

8:40-6.20 Obstetrical kit

(a) An obstetrical kit shall be carried in the vehicle. The items may be individually wrapped or be contained in a "pack." Any pack shall have an exterior itemized list of contents. Items shall include the following:

1. *[Five]* ***Four*** towels:

2. Twelve sterile gauze compresses, four inches by four inches;

3. Four sterile cord clamps;

4. One sterile bulb syringe, soft rubber (for newborn aspiration);

5. One receiving blanket;

6. Four pairs sterile surgeons' type gloves;

7. One pair sterile scissors or a sterile scalpel; ***and***

8. One set of eye protection or goggles*[; and]* ***.***

[9. One box (12) sanitary pads.]

8:40-6.21 Poison treatment supplies

(a) The following poison treatment supplies shall be carried in the vehicle:

1. Four liquid ounces Syrup of Ipecac; and

2. Four, three- to four-ounce bottles prepackaged liquid activated charcoal.

8:40-6.22 Other patient care equipment

(a) There shall be the following other minimum patient care equipment:

1. Diaphragm-type stethoscope;

2. Aneroid-type blood pressure manometer and adult size cuff, obese adult size cuff and pediatric cuff;

3. Four sugar packets or one fluid ounce of glucose in form easily ingested by mouth.

4. Four cloth blankets at least 60 inches by 80 inches in size from September 15 to May 1 and two blankets the rest of the year;

5. Two penlights suitable for patient examination;

6. *[Four "cold packs" and two "hot packs";]* ***One set of eye protection or goggles to supplement the set in the obstetrical kit.***

7. Four towels;

8. At least six plastic bags in assorted sizes;

9. Twelve pairs surgeons' type ***latex*** gloves; and

10. Two sets of personnel protection isolation garments, including gowns and masks.

(b) The licensee shall provide such other equipment and supplies as may be necessary, provided no equipment or supplies shall be carried which would permit rendering of care contrary to N.J.S.A. 45:9-1 et seq. (Practice of Medicine and Surgery Act). Equipment which would permit staff to render care at the Emergency Medical Technician-Intermediate level or the Emergency Medical Technician-Defibrillator level may be carried, if the vehicle is approved to operate as part of an approved program authorized by the Commissioner.

8:40-6.23 Extrication equipment

(a) Except as permitted in (b) below, the following minimum extrication and related equipment shall be carried on the vehicle:

1.-7. (No change.)

8. One wrecking bar, at least 24-inch length (Items 6, 7 and 8 can be combined as one tool.);

9. One crow bar, at least 36-inch length with pinch point;

10. One bolt cutter with at least one and a quarter inch jaw opening;

11. One portable hydraulic set consisting of at least one hand operated four-ton or greater capacity hydraulic pump and one ton capacity spreading jaws and at least one spare pint of hydraulic fluid;

12. One shovel, pointed blade, at least 49 inches long when open (either folding or non-folding type acceptable);

13. Two manila, polypropylene, or equivalent material ropes with at least 5400 pounds tensile strength, at least 50 feet long;

14. One set hand-operated ratchet hoist set ("come along"® type) two-ton capacity with separate 15-foot long, two-ton capacity chain (one end with grab hook, other end with running hook);

15. A heavy rescue hydraulic tool (for example, "Jaws of Life"®, Hurst Tool®) with associated attachments may be substituted for items 11 and 14 above;

16. Sheet metal cutting tool;

17. Two pairs safety goggles, clear;

18. Two hard hats. Bump-type or heavier;

19. Two pairs gloves, leather palm with wrist gauntlets; and

20. Two sets protective outer garments (for example, "turnout" coats and trousers).

(b) The extrication and related equipment required in (a) above need not be carried when:

1. The Ambulance does not respond to automobile, industrial or other accidents. However, Ambulances which do not carry extrication equipment may stop and render emergency medical care at an accident scene which they pass by chance; or

2. A rescue vehicle is available and:

i. Operators of the rescue vehicle agree, in writing, to provide extrication services for patients under the licensee's care;

ii. Can respond to an accident location within six minutes; and

iii. The rescue vehicle carries all of the equipment and related material required in (a) above.

8:40-6.24 Safety equipment

(a) The vehicle shall have the following minimum safety equipment:

1. Three portable red emergency reflective safety triangles or three battery-operated flashers, to be used in cases of onscene assistance or vehicle breakdown;

2. Six flares for use in assisting in aeromedical transports;

3. One flashlight, two D cell size or larger; and

4. One or two fire extinguisher(s), U.L. rated at least 1A 10BC in total. The fire extinguisher(s) shall have either a gauge indicating it is fully charged or a current inspection tag.

(b) All vehicles which provide "street EMS" or which routinely respond to motor vehicle accidents shall be equipped with a current U.S. Department of Transportation guidebook for initial response to hazardous materials incidents, as well as a copy of the applicable local emergency operations plan (EMS Annex).

8:40-6.26 Required training of staff

(a) Each of the required staff persons shall possess current valid certification as an Emergency Medical Technician-Ambulance, issued by the Department.

(b) (Reserved)

(c) Each of the required Emergency Medical Technicians-Ambulance shall possess valid current certification in cardiopulmonary resuscitation for emergency services personnel, issued by the American Heart Association (BLS-C: CPR for Healthcare Providers) or the equivalent American Red Cross course.

8:40-6.27 Duties of staff

(a) The collective duties of the persons who staff an Emergency Ambulance vehicle shall include, but are not limited to:

1. Providing prompt, efficient and effective emergency medical care to the patient(s);

2.-4. (No change.)

5. Assuring that any stretcher, wheelchair or other patient transport device is safely and properly restrained, patients are restrained and all vehicle occupants wear automotive safety belts. *[Any child passenger must be properly restrained in a Federally-approved child safety seat.]* The staff person(s) caring for the patient need not wear a safety belt when providing essential life support such as CPR;

6.-7. (No change.)

8. For seriously ill or injured patients, notifying the medical facility, prior to arrival, that special professional services and assistance will be needed;

9. Complying with applicable laws and regulations on the handling of the deceased;

10. Entering data into and signing the required call report; and

11. Prohibiting smoking within the vehicle at all times.

8:40-6.28 Special staff required

(a) When the Emergency Ambulance is utilized to provide an inter-hospital transfer of a neonatal patient, the vehicle shall be staffed by:

1. *[The]* ***At least one of the*** two persons required in N.J.A.C. 8:40-6.25; and

2. Specialist staff consisting of a physician and either a nurse or a respiratory therapist, all of whom have been specially trained to care for neonatal patients.

(b) When the Emergency Ambulance is utilized to transport a patient receiving intravenous fluids and/or medications, the vehicle shall be staffed by:

1. The two persons required in N.J.A.C. 8:40-6.25; and

2. One of the following:

i. A physician;

ii. A registered professional nurse;

iii. A licensed Mobile Intensive Care Unit Paramedic providing medical care as part of a designated Mobile Intensive Care Program operated in accordance with N.J.S.A. 26:2K-7 et seq.; or

iv. An employee of the "sending" or "receiving" hospital who has been specifically assigned by the hospital to care for the patient who is receiving intravenous therapy. It is the hospital's responsibility to ensure that any assigned employee is certified, or otherwise qualified, to oversee intravenous therapy.

(c) All provisions of this section shall become null and void upon adoption of critical care transport unit regulations, which shall include reference to these situations.

8:40-6.29 Call report

(a) A call report approved by the Department shall be completed each time a patient is transported. One call report will suffice for both legs of a round trip. The call report shall be prepared by the staff assigned to the vehicle and shall contain the following information printed in ink:

1. The patient's name, age, sex and home address;

2. A description of the patient's condition at the scene and in transit;

3. A description of care given to the patient at the scene and in transit;

4. Time when, and location where, patient was picked up and was discharged;

5. The vehicle recognition number, date, full names of staff, including special staff and their affiliation;

6. Whether or not emergency warning devices were used responding to the scene, at the scene, or in transit to the medical facility; and

7. Any required equipment left on/with a patient.

(b) (No change.)

8:40-6.30 Radio communications

(a) (No change.)

(b) Any radio communications shall comply with the radio frequency allocation cited in Table 4 of the JEMS Communications Plan published by the Department, or the appropriate table in any future revision of the JEMS plan. Specifically:

1. None of the UHF radio frequencies known as "Med 1" through "Med 10" shall be used in radio communications to, or from, any Emergency Ambulance vehicle;

2. None of the VHF radio frequencies listed in Appendix A of this chapter shall be used in radio communications to, or from, any Emergency Ambulance vehicle unless the vehicle is operated by a municipality or operated under contract to a municipality to provide emergency medical services to a political subdivision (that is, the vehicle does "street work"), and/or the vehicle responds to motor vehicle accidents, and/or the vehicle responds to nursing homes;

3. The radio frequency 155.340 MHz shall only be used for essential communications between an emergency ambulance and a hospital Emergency Department; and

4. The radio frequency 155.280 MHz shall only be used for essential communications between cooperating emergency ambulances and as a "back-up" dispatch channel for Emergency Ambulance vehicles which serve a political subdivision.

(c) The provisions of (b) above shall not apply if:

1. The provider was issued a Federal Communications Commission license before January 1, 1978 to use one (or more) of the cited frequencies; and

2. The provider is using that same frequency(ies); and

3. Use of that frequency(ies) does not cause harmful interference to other health care providers operating in accordance with the JEMS Plan.

(d) For the purpose of this section, harmful interference is defined as:

1. A written complaint alleging radio interference from a health care provider(s) operating in accordance with the JEMS Plan; and

2. A finding by the New Jersey Office of Frequency Coordination (or, if their services are not available, the Department) that the provider's radio operations are causing harmful interference.

(e) Each Emergency Ambulance shall be equipped with a mobile radio(s) with the following minimum capabilities:

1. Two-way, VHF high-band with Effective Radiated Power (ERP) as approved by the New Jersey Office of Frequency Coordination;

2. Able to select, and to transmit and receive on, each of the required radio frequencies from the driver's compartment;

3. Able to transmit and receive on the selected radio frequency from the patient compartment by suitable means (such as a handset-type microphone); and

4. Functional, dual-tone, multi-frequency ("Touch-tone"® type) encoder in either the driver's or patient compartment.

(f) Each Emergency Ambulance which is used to provide emergency medical services to a political subdivision (whether it is operated directly by a municipality or under contract with a municipality to do "street work")*[, and/]*or which responds to motor vehicle accidents*[, and/or which responds to nursing homes]* shall have the following four operating radio frequencies and functional continuous tone coded squelch system (CTCSS) in its mobile radio, in addition to the mobile radio capabilities listed in (e) above:

1. 155.xxx MHz (local EMS frequency and CTCSS as listed in Appendix A);

2. 155.340 MHz (ambulance-to-hospital Emergency Department);

3. 155.280 MHz (statewide EMS coordination); and

4. 153.785 MHz (statewide public safety coordination for police, fire and EMS), or;

(g) All other Emergency Ambulances (that is, those which do not provide any of the services listed in (f) above) shall have at least the two following operating radio frequencies and functional continuous tone coded squelch (CTCSS) in their mobile radios, in addition to the other mobile radio capabilities listed in (e) above:

1. 155.340 MHz (ambulance-to-hospital Emergency Department); and

2. 155.280 MHz Statewide EMS coordination.

(h) Each in-service Emergency Ambulance which provides service to a political subdivision ("street EMS") either directly or under contract, and*[/or]* which responds to motor vehicle accidents*[, and/or which responds to nursing homes]* shall be equipped with at least one portable radio with the following minimum capabilities:

1. Two-way, four-frequency, VHF high-band;
2. Able to select, and to transmit and receive on, each of the four required radio frequencies; and
3. The same four operating radio frequencies and CTCSS as required in (f) above.

(i) A licensee which is part of a local, county, or regional disaster plan must have the appropriate radio communications elements which would enable it to carry out its role under the plan.

8:40-6.31 Disaster planning required

(a) Each licensee which provides service to a political subdivision or a government installation shall participate, in conjunction with the applicable office of emergency management, in the development of an emergency medical services plan or an annex to a basic disaster plan. The emergency medical services plan/annex shall be reviewed and tested at least once a year. Employees shall be informed of their responsibilities under the plan at least twice a year. The licensee shall conduct an analysis of equipment and personnel at least twice a year to determine its capabilities to respond to emergencies which can reasonably be expected to occur in its service area.

(b) The licensee shall describe in the plan/annex the specific means that will be used to summon off-duty personnel and mutual aid ambulances.

(c) Each Emergency Ambulance which serves a political subdivision or government installation or which responds to motor vehicle accidents shall carry one package (50) medical emergency triage tags (METTAG®) for use in patient identification and triage during mass casualty incidents.

SUBCHAPTER 7. SPECIFIC HELICOPTER AMBULANCE REQUIREMENTS

8:40-7.1 Patient restrictions

(a) Emergency aeromedical care and transportation in a helicopter ambulance shall be provided to a patient who:

1.-2. (No change.)

8:40-7.2 General helicopter requirements

(a) (No change.)

(b) Each helicopter approved under this chapter shall be licensed and operated in accordance with applicable portions of the Federal Aviation Regulations (FAR).

(c) (No change.)

(d) Each helicopter used to provide helicopter aeromedical ambulance service shall be approved by the Department.

8:40-7.3 Patient compartment requirements

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

(d) There shall be space and seating for at least two attendants within the patient compartment. Each seat shall be equipped with a safety belt. Velcro®-type closures are prohibited.

(e) (No change.)

8:40-7.6 Special lighting required

Each helicopter licensed under this chapter shall be equipped with a forward-facing, exterior, high-powered floodlight.

8:40-7.7 General equipment and supplies requirement

All equipment and supplies shall be stowed within the aircraft in a safe, crashworthy manner.

8:40-7.8 Standard patient transport devices

(a) There shall be a litter for the transport of stretcher bound patients. The litter shall be at least 72 inches long (when flat) and at least 20 inches wide.

(b) The litter shall have three sets of two-inch wide patient restraints with quick release buckles positioned at the chest, waist and knees. The quick release buckles may be of the "slide-through" or "metal to metal" type. Velcro®-type closures are prohibited.

(c) (No change.)

8:40-7.9 Oxygen administration devices

(a) The aircraft shall have a medical oxygen system which is capable of delivering oxygen to the patient at a rate of at least 15 liters per minute during the entire time the patient is aboard the aircraft.

(b) The oxygen cylinder controls shall be accessible from the required attendant's seat. Cylinder opening wrench(es) or handles shall be affixed to or chained and clipped to the oxygen cylinder(s).

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

8:40-7.10 Resuscitation devices

(a) (No change.)

(b) The aircraft shall be equipped with resuscitation devices in accordance with N.J.A.C. 8:40-6.14(c) through (f).

8:40-7.11 Aspirator/suction devices

(a) There shall be an installed suction device powered by the aircraft's electrical system. The device shall be securely mounted and located to permit aspiration of any stretcher bound patient. The device shall meet the criteria contained in N.J.A.C. 8:40-6.15(c) and (d) during the entire normal range of aircraft operation.

(b) There shall be a portable device powered by an integral battery. The device shall meet the criteria contained in N.J.A.C. 8:40-6.15 (c) and (d) for at least 20 minutes. In recognition of aircraft weight limitations, the portable suction device may also be used as the installed device provided it meets the requirements of (a) above.

8:40-7.12 Airway maintenance supplies

(a) There shall be at least the following airway maintenance supplies:

1. Two bite sticks single-service type; and
2. At least 14 airways in at least four different adult and child sizes.

8:40-7.13 External cardiac compression support

A rigid surface shall be immediately available to facilitate external cardiac compressions on a patient requiring cardiopulmonary resuscitation.

8:40-7.14 Wound dressing and burn treatment supplies

(a) The following wound dressing and burn treatment supplies shall be carried in the aircraft:

1. Four conforming roller bandages, at least three inches wide;
2. Four triangular bandages (cravats) measuring 36 inches by 36 inches by 51 inches when unfolded;
3. Four sterile, individually packed universal dressings measuring at least nine inches by 30 inches when unfolded;
4. Twenty-four sterile, individually packed gauze pads at least four inches by four inches;
5. One roll adhesive type tape;
6. Two sterile, individually packed occlusive dressings or one sterilized roll of aluminum foil;
7. Two sterile, individually wrapped burn sheets, or other burn care products approved by the Commissioner; and
8. One liter sterile saline solution in a plastic container(s) (for flushing injury sites). Saline solution shall be current (not expired).

8:40-7.15 (No change in text.)

8:40-7.16 Other patient care equipment

(a) There shall be the following other minimum patient care equipment:

1. (No change.)
2. Aneroid type blood pressure manometer and adult and pediatric sized cuffs; and
3. Four sugar packets or one fluid ounce of glucose in a form easily ingested by mouth.

8:40-7.17 Required staff

When in service, each Helicopter Ambulance shall be staffed by at least two persons, not including the pilot.

8:40-7.18 Required training of staff

(a) Each of the required aeromedical staff persons shall be either a registered professional nurse or a certified paramedic who has received additional specialized training in aeromedical care and has successfully passed an examination administered by the New Jersey State Department of Health and has been approved by the Commissioner.

(b) Additional specialty staff, such as physicians, nurses or respiratory therapists, may be part of the aeromedical crew. If these persons are employees of the "sending" or "receiving" hospital or of the designated aeromedical provider, the hospital or provider shall ensure that the person(s) is certified, or otherwise qualified, to care for the specialty patient being transported.

8:40-7.19 Duties of staff

(a) The collective duties of the persons who staff a helicopter ambulance shall include, but are not limited to:

1. The duties cited in N.J.A.C. 8:40-6.27 (excluding N.J.A.C. 8:40-6.27(a)6;

2. Assuring that all ground personnel who may help load/unload the aircraft observe appropriate safety procedures; and

3. Prohibiting smoking within 100 feet of the aircraft at all times.

8:40-7.20 Call report

(a) A call report approved by the Department shall be completed each time a patient is transported. The call report shall be prepared by the medical staff who provided in-flight patient care and shall contain the information required in N.J.A.C. 8:40-6.29 printed in ink.

(b) (No change.)

8:40-7.21 Radio communications

(a) All radio communications shall comply with rules and regulations of the Federal Communications Commission. The Department shall be provided with a copy of any FCC license(s) issued to the licensee.

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

8:40-7.22 Special prohibitions

(a) In recognition of the potential hazards of the aircraft environment, the following are specifically prohibited:

1.-2. (No change.)

3. Free swinging traction weights;

4. Glass or rigid plastic intravenous containers; and

5. Any patient care or other equipment which causes electromagnetic interference to the aircraft equipment.

Appendix A (No change in text.)

(a)

DIVISION OF HEALTH POLICY AND RESEARCH

Recognized Public Health Activities and Minimum Standards of Performance for Local Boards of Health in New Jersey.

Readoption: N.J.A.C. 8:52

Proposed: September 16, 1991 at 23 N.J.R. 2825(a).
Adopted: December 9, 1991 by the Public Health Council, Louise Chut, Ph.D., Chairperson.
Filed: December 11, 1991 as R.1992 d.24, **without change.**

Authority: N.J.S.A. 26:1A-15.

Effective Date: December 11, 1991.
Expiration Date: December 11, 1996.

Summary of Public Comments and Agency Responses:

The Department received two written comments on the rules proposed for readoption; one from the Ocean County Health Department and the other from the office of the Passaic County Health Officer during the public comment period which closed October 16, 1991. These letters are on file at the Health Aid Services Program of the Department.

The Department recognizes the validity of these recommendations but will not be making any amendments in the content of these rules at this time. The revision of all these rules will be done simultaneously to coincide with the completion of the State Health Plan to ensure consistency between these two documents.

The following is a summary of the comments submitted in reference to the proposed rules and the corresponding Departmental response.

COMMENT: Ocean County Health Department requested consideration be given to reducing the required number of inspections for recreational bathing facilities from two to one during the operating season.

RESPONSE: The Department acknowledges the commenter's concerns regarding the frequency of inspecting recreational bathing facilities. However, amendments to the existing standards are not being submitted at this time so that the revisions will be compatible with the State Health Plan which is currently being developed by the State Health Department. Language consistent with this recommendation has already been approved by the Minimum Standards Advisory Committee for inclusion in the upcoming revision.

COMMENT: The Passaic County Health Officer commented that it would be appropriate to tie Minimum Standards to the Health Care Cost Reduction Act. It is suggested that a stronger health planning element be incorporated into these standards with the primary focus on the development of individual health plans for each of the separate counties located in the jurisdiction of the six regional health planning boards. The commenter believes building this type of relationship between the boards and local health officials will improve the quality and delivery of public health services.

RESPONSE: The Department is currently in the process of developing the State Health Plan which is designed to improve the delivery of health care and preventive services provided at the community level. The design of this Plan is based on quantifiable data to determine health status and community health needs. Minimum Standards has been proposed for readoption to provide the Department and the Minimum Standards Advisory Committee with the opportunity to reassess their completed work and design the revisions so that they are consistent with the principles of the State Health Plan.

Full text of the readoption may be found in the New Jersey Administrative Code at N.J.A.C. 8:52.

(b)

DRUG UTILIZATION REVIEW COUNCIL

List of Interchangeable Drug Products

Adopted Amendments: N.J.A.C. 8:71

Proposed: September 3, 1991 at 23 N.J.R. 2610(a).
Adopted: December 11, 1991, by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: December 11, 1991, as R.1992 d.25, **with a portion of the proposal not adopted and with portions not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 6, 1992.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comments pertaining to the products affected by this adoption.

COMMENT: In opposition to Mutual Pharmaceutical Company's and Geneva Pharmaceutical's (formerly Cord Laboratories) tolmetin, McNeil Pharmaceutical stated that no generic versions of Tolectin have received FDA approval.

RESPONSE: The Council verified that Mutual's tolmetin has received FDA approval for marketing with an "AB" therapeutic equivalency rating and agreed to defer taking action on Geneva's tolmetin pending FDA approval.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the List of Interchangeable Drug Products was held on September 24, 1991. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. Two persons attended the hearing. Six comments were received as summarized in a previous Register (see 23 N.J.R. 3334(b)). The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified "not adopted," and referred the products identified as "pending" for further study.

A record of the public hearing may be reviewed or obtained by contacting:

Eileen O'Donnell, Administrative Practice Officer
Department of Health
CN 360
Trenton, New Jersey 08625

The following products and their manufacturers were **adopted**:

Amoxapine tabs 25, 50, 100, 150 mg	**Cord**
Carisoprodol tabs 350 mg	**Mutual**
Ergoloid mesylates tabs 1 mg	**Mutual**
Tolmetin tabs 200 mg and caps 400 mg	**Mutual**

The following product and its manufacturer was **not adopted**:

Ethinyl estradiol .035, Norethindrone .5 mg	Syntex

The following drugs were **not adopted but are still pending**:

Albuterol tabs 2, 4 mg	Purepac
Atenolol tabs 50, 100 mg	W-C
Cephalexin 250, 500 mg	Yoshitomi
Chlorthalidone tabs 25, 50, 100 mg	Zenith
Clemastine fumarate tabs 1.34, 2.68 mg	Lemmon
Cyclobenzaprine tabs 10 mg	Cord
Ibuprofen tabs 200, 400, 600, 800 mg	Invamed
Loperamide HCL caps 2 mg	Lemmon
Methocarbamol tabs 500, 750 mg	Mutual
Minoxidil tabs 2.5, 10 mg	Mutual
Piroxicam caps 10, 20 mg	Mutual
Propoxyphene caps/APAP 50/325, 100/650	Mutual
Stuartnatal 1+1 substitute	J. Stevens
Sulindac tabs 150, 200 mg	Purepac
Tolmetin caps 400 mg	Cord
Trazodone tabs 50, 100 mg	Mutual
Triamterene/HCTZ tabs 37.5/25	Cord
Verapamil tabs 40 mg	Cord
Verapamil tabs 40 mg	Purepac

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 23 N.J.R. 3334(b).

(a)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: May 20, 1991 at 23 N.J.R. 1509(a).
Adopted: December 11, 1991, by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: December 11, 1991, as R.1992 d.26, **with portions of the proposal not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 6, 1992.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

COMMENT: In opposition to Novopharm's tolmetin, McNeil Pharmaceutical stated that no generic versions of Tolection have received FDA approval.

RESPONSE: The Council verified that Novopharm's tolmetin has received FDA approval for marketing with an "AB" therapeutic equivalency rating.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the list of interchangeable durg products was held on June 11, 1991. Thomas T. Culkin, Pharm. D., M.P.H., served as hearing officer. Four persons attended the hearing. Six comments were offered as summarized above and in the previous adoption notice at 23 N.J.R. 3336(a). The hearing officer recommended that the decisions made be based upon available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified as "not adopted," and referred the products identified as "pending" for further study.

A record of the public hearing may be reviewed or obtained by contacting:

Eileen O'Donnell, Administrative Practice Officer
Department of Health
CN 360
Trenton, New Jersey 08625

The following products and their manufacturers were **adopted**:

Fenoprofen cabs 200 mg & 300 mg	**W-C**
Tolmetin sodium caps 400 mg	**Novopharm**

The following products were **not adopted but are still pending**:

Amiloride/HCTZ tabs 5/50	Danbury
Betamethasone valerate lotion 0.1%	Clay-Park
Clorazepate tabs 3.75, 7.5, 15 mg	Danbury
Cyclandelate caps 200, 400 mg	Amide
Desoximetasone cream 0.05, 0.25%	Taro
Dipyridamole tabs 25, 50, 75 mg	Lederle
Duofilm substitute	C&M
Entex LA tabs substitute	Sidmak
Fenoprofen tabs 600 mg	W-C
Iodinated glycerol soln 50 mg/5 ml	Cenci
Leucovorin tabs 25 mg	W-C
Loperamide caps 2 mg	W-C
Minocycline caps 100 mg	Danbury
Natalins RX tabs substitute	Amide
Propranolol/HCTZ tabs 40/25, 80/25	Danbury
Stuartnatal 1+1 tabs substitute	Amide
Sulindac tabs 150, 200 mg	W-C
Temazepam caps 15, 30 mg	Danbury
Timolol maleate tabs 5, 10, 20 mg	W-C
Tolmetin tabs 200 mg, caps 400 mg	W-C

OFFICE OF ADMINISTRATIVE LAW NOTE: See related notice of adoption at 23 N.J.R. 3336(a).

(b)

DRUG UTILIZATION REVIEW COUNCIL
List of Interchangeable Drug Products
Adopted Amendments: N.J.A.C. 8:71

Proposed: November 4, 1991 at 23 N.J.R. 3258(a).
Adopted: December 11, 1991, by the Drug Utilization Review Council, Robert Kowalski, Chairman.
Filed: December 11, 1991, as R.1992 d.27, **with portions of the proposal not adopted and with portions not adopted but still pending.**

Authority: N.J.S.A. 24:6E-6(b).

Effective Date: January 6, 1992.
Expiration Date: February 17, 1994.

Summary of Public Comments and Agency Responses:

The Drug Utilization Review Council received the following comments pertaining to the products affected by this adoption.

COMMENT: Regarding "Benzatropine mesylate tabs 1mg, 2mg," Mutual Pharmaceutical, its manufacturer, pointed out that the proposal should state "Benztropine" mesylate tabs 1mg and 2 mg. (The proposal has a typographical error).

RESPONSE: The Council agreed and will consider this product under the correct spelling, "benztropine mesylate 1 mg & 2 mg" tablets. However, this product was deferred pending FDA approval.

COMMENT: In opposition to Mutual Pharmaceutical's pindolol, Sandoz Pharmaceutical Corporation, manufacturer of the brand Visken, stated that Mutual has not received FDA approval to market a brand of pindolol. In addition, Sandoz understands that it is not the deposition of the Council to concern itself with patent protection. As information, Sandoz noted that under the Hatch-Waxman legislation, data exclusivity of its brand of pindolol, Visken, has been extended to September 3, 1992. Sandoz advises that appropriate action would be undertaken should such exclusivity be violated by any manufacturer.

RESPONSE: The Council deferred taking action on this product pending FDA approval.

COMMENT: From Boots Pharmaceutical Group in opposition to Jerome Stevens Pharmaceutical's levothyroxine sodium tabs 25, 50, 75, 100, 125, 150, 200 and 300 mcg.

Boot's requests that J. Stevens' levothyroxine should not be considered until bioequivalency data is submitted and made available to interested parties for analysis and comment.

RESPONSE: The Council deferred taking action pending receipt and review of pertinent biodata from Jerome Stevens Pharmaceutical on its levothyroxine products.

COMMENT: From Janssen Pharmaceutica, a Johnson & Johnson company, in opposition to Novopharm's loperamide caps 2 mg.

Janssen informed the Council that the treatment of diarrhea is the balancing of efficacy against possible side effects. Janssen stated that its brand name of loperamide, Imodium, has provided highly effective relief from the discomforts and problems associated with diarrhea.

Janssen noted that the treatment of diarrhea needs consistent and effective medication. Janssen pointed out that patients effectively controlled with Imodium would NOT be well served by being switched to a generic product which could result in loss of bowel control. Janssen contends that these patients would NOT be well served from either a cost or health perspective.

Janssen noted that there are differences between Novopharm's loperamide and Imodium based on the biodata submitted. Janssen stated that Imodium capsules release their medication significantly faster than Novopharm's and reach peak blood levels much more quickly. In addition, Imodium releases the drug more uniformly.

RESPONSE: The Council unanimously approved Novopharm's loperamide 2 mg capsules based on the acceptable comparative values of the AUC and C-max and the acceptable range of the 90 percent confidence intervals.

Summary of Hearing Officer's Recommendations and Agency Responses:

A public hearing on the proposed additions to the List of Interchangeable Drug Products was held on November 25, 1991. Mark A. Strollo, R.Ph., M.S., served as the hearing officer. Seven persons attended the hearing. Four comments were received as summarized above. The hearing officer recommended that the decisions be made based upon the available biodata. The Council adopted the products specified as "adopted," declined to adopt the products specified "not adopted," and referred the products identified as "pending" for further study.

A record of the public hearing may be reviewed or obtained by contacting:

Eileen O'Donnell, Administrative Practice Officer
Department of Health
CN 360
Trenton, New Jersey 08625

The following products and their manufacturers were **adopted**:

Chloral hydrate syrup	**LuChem**
Hydrocodone/APAP tabs 2.5/500	**Watson**
Hydrocodone/APAP tabs 7.5/500	**Watson**
Hydrocodone/APAP tabs 7.5/750	**Watson**
Hydroxyzine Pamoate caps 25mg	**Danbury**
Iodinated glycerol soln 50mg/ml	**LuChem**
Iodinated glycerol tabs 30mg	**LuChem**
Loperamide caps 2mg	**Novopharm**
Rondec DM drops substitute	**Esquire**

The following products and their manufacturers were **not adopted**:

Mephobarbital tabs 32, 50, 100mg	Ferndale Labs.
Naphcon-A opth soln substitute	Optopics
Norpace CR caps substitute 100, 150mg	KV Pharm.
Proctocort cream substitute	Amer. Generics
Tetracaine 0.5% opth soln	Optopics

The following drugs were **not adopted but are still pending**:

Benztropine mesylate tabs 1, 2mg	Mutual
Levothyroxine sodium tabs 25, 50, 75 mcg	J. Stevens
Levothyroxine sodium tabs 100, 125, 150mcg	J. Stevens
Levothyroxine sodium tabs 200, 300mcg	J. Stevens
Metoclopramide 10mg tabs	Mutual
Metoprolol tartrate tabs 50, 100mg	Mutual
Pindolol tabs 5, 10mg	Mutual

PUBLIC NOTICES

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Notice of Code Change Proposal Hearing

Take notice that the Construction Code Element of the Division of Housing and Development, Department of Community Affairs, has scheduled its annual code change proposal hearing **for the plumbing subcode only**, pursuant to N.J.S.A. 52:27D-123, for February 7, 1992 beginning at 9:30 A.M., in the first floor conference room of Building 3 of 3131 Princeton Pike, Lawrenceville, New Jersey.

Persons wishing to present code change proposals for the National Standard Plumbing Code, which has been adopted by reference as the plumbing subcode of the State Uniform Construction Code, or those in need of further information, may telephone the Element at (609) 530-8789.

Proposals may be mailed or faxed to:

"Code Changes"
Department of Community Affairs
Bureau of Technical Services
CN 816
Trenton, NJ 08625-0816
Fax: (609) 530-8858

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

ENGINEERING AND CONSTRUCTION ELEMENT

Notice of Receipt of Petition for Rulemaking
N.J.A.C. 7:13-7.1

Petitioner: Jack Kocsis, Jr.

Take notice that on November 21, 1991, the Department of Environmental Protection and Energy (Department) received a petition for rulemaking concerning the amendment of the Department's regulations governing delineated floodways.

The petitioner is the owner of a dwelling located within the flood plain of the Delaware River in Pohatcong Township, Warren County. The Petitioner asserts that he has applied for and been denied a Stream Encroachment Permit for the construction of an addition to the dwelling.

The Petitioner seeks an amendment to the delineated floodway depicted in the map entitled "Delineation of Floodway and Flood Hazard Area, Delaware River, Mile 178.59 to Mile 1802.4" prepared by Michael Baker Jr., Inc., dated 1978, as referenced in N.J.A.C. 7:13-7.1. The Petitioner asserts that the delineation of the floodway is inaccurate.

(c)

OFFICE OF REGULATORY POLICY

Amendment to the Northeast Water Quality Management Plan
Public Notice

Take notice that on October 23, 1991, pursuant to the provisions of the 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 Northeast Water Quality Management (WQM) Plan was adopted by the Department. This amendment, submitted by the Florham Park Sewerage Authority (FPSA), adopts a Wastewater Management Plan (WMP) for the FPSA. The WMP allows for a new sewage treatment plant (STP), with discharge to the Passaic River, to serve the proposed Sun Valley at Florham Park development and an additional adjacent proposed development. The total projected wastewater flow to the Sun Valley STP is 0.155 million gallons per day. The WMP also delineates the areas of Florham Park and East Hanover which are in the sewer service area of the Florham Park STP and the area of Florham Park served by the Morris Woodland STP.

This amendment was noticed in the New Jersey Register on April 1, 1991. Comments on this amendment were received during the public comment period and are summarized below with the Department's responses.

COMMENT: This proposed amendment would direct increased sewage (3,000 gallons per day) from part of Florham Park to the Morris Woodland STP. This increase in flow, regardless of how small, seems inappropriate given the frequent flooding conditions and ongoing degradation currently affecting the Great Swamp National Wildlife Refuge and Watershed. The additional flow would only exacerbate the already existing water quantity and quality problems.

RESPONSE: The additional flow of 3,000 gallons per day is from existing homes in Florham Park which were intended to be served by the Morris Woodland STP as per a contract between the Sisters of Charity of Saint Elizabeth, Morris Township, Florham Park Borough and the FPSA. The additional flow represents a minor contribution to the Great Swamp Watershed and would be offset by the environmental benefit of remediation of the failing septic systems at the existing homes.

COMMENT: According to the Northeast Water Quality Management Plan (WQMP), the need existed within Morris Township for 2.0 million gallons per day (mgd) of capacity at the Morris Woodland STP. If Florham Park hooks up to the Morris Woodland STP, does that mean that Morris Township does not need 2.0 mgd? If so, what has occurred to diminish their need? Would this connection alter the average flows so that an increase would occur more frequently? What will be the impact on the Loantaka Brook, Morris County Parkland and on the Great Swamp? Cumulatively, what will be the impact of the proposed interbasin transfer of water?

RESPONSE: According to the Northeast WQMP, capacity in the Morris Woodland STP was provided as follows:

Morris Township	1.2 mgd—residential
	.6 mgd—industrial
	.2 mgd—I/I
Harding Township	.1 mgd—residential

The Northeast WQMP did not provide for Madison and Florham Park Boroughs and the Town of Morristown to be served. However, portions of these municipalities are currently served by the Woodland STP. These municipalities take up some of the capacity previously provided to Morris Township. Also, according to the Environmental Review for the loan application, a 2010 population of 9,549 in Morris Township is to be served by the Woodland STP, not 11,000 as specified in the Northeast WQMP. Therefore, the need is less than previously specified in the Northeast WQMP.

In response to the question regarding impact on the receiving waters from this additional flow, the Woodland STP is not proposed to be expanded to address this flow; therefore, this is not an issue.

COMMENT: This proposed amendment would require approval of Morris Township's New Jersey Pollutant Discharge Elimination System (NJPDES) permit modification which seeks to increase the monthly maximum effluent discharge limitation, and thereby flows, for the Morris Woodland STP.

RESPONSE: The flows specified in this WMP do not require the approval of a modified NJPDES permit for the Morris Woodland STP.

COMMENT: When and under what permits did the Morris Woodland Treatment Plant start accepting sewage flows from Florham Park?

RESPONSE: The area of Florham Park served by the Woodland STP consists of the area tributary to the Sisters of Charity pumping station for which a construction permit was issued by the Department on October 9, 1980.

COMMENT: A proposed plan for the Morris Woodland STP proposes to provide Harding Township with increased capacity of 10,900 gallons per day, resulting in less total gallonage than provided for Harding Township in the Northeast WQMP and the final draft Environmental Impact Statement for the Upper Passaic River Basin Facilities Plan. Does Harding Township agree to this flow reduction? If not, what provisions are being made for the Harding Township flow?

RESPONSE: It is not clear what proposed plan is being referred to above; however, the flow numbers specified in the Northeast WQMP may be changed through amendments. Harding Township must be requested to endorse any amendment that relates to the Woodland STP service area in Harding Township and the associated wastewater flows. This is not, however, pertinent to the FPSA WMP.

COMMENT: In the Environmental Impact Statement on the 201 Facilities Plan for the Upper Passaic River Basin, the U.S. Environmental Protection Agency (U.S. EPA) recommended that the treatment capacity for the Morris Woodland STP be reduced from 2.0 mgd to 1.8 mgd in order to improve the water quality of Loantaka Brook. The proposed action contemplated in the proposed amendment would appear to be inconsistent with the U.S. EPA's recommendation.

RESPONSE: As previously discussed, the proposed amendment does not provide for any expansion of the Woodland STP nor does it address total projected wastewater flow to the Woodland STP. This must be addressed in a separate amendment for Morris Township.

COMMENT: What impacts will the development of 135 acres in the Black Brook Watershed have on Black Meadows, a highly valuable Passaic Basin wetland already severely impacted by loss of wetlands due to construction of Route 24?

RESPONSE: This is not an issue pertinent to the FPSA WMP.

COMMENT: The proposed amendment seems to contradict former Commissioner Christopher Daggett's Administrative Order #51 which recognizes widespread concern about the effects of urbanization on the Great Swamp Watershed and directs the Department of Environmental Protection to assume a broader regional approach to regulatory decisions in the Great Swamp Watershed.

RESPONSE: As the Borough of Florham Park is not within the Great Swamp Watershed and the proposed additional flow to the Woodland STP will not require STP expansion and will be derived from existing Woodland STP sewer service area, the above comment is not applicable to this amendment.

(a)

OFFICE OF REGULATORY POLICY

Amendment to the Monmouth County Water Quality Management Plan
Public Notice

Take notice that on October 23, 1991, pursuant to the provisions of the 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 Monmouth County Water Quality Management Plan was adopted by the Department. This amendment, submitted by Mr. Glenn Neighbour, adopts the designation of the site of Cedar Hollow Estates Townhouse Complex (Block 801, Lot 2) in Wall Township as a non-surface discharge (less than 20,000 gallons per day) service area to serve the 11 unit complex. Two on-site subsurface disposal systems are proposed to treat a projected wastewater generation of 3,300 gallons per day. The project site is within the service area of the South Monmouth Regional Sewerage Authority and will be required to tie into the sewer system when available.

(b)

OFFICE OF REGULATORY POLICY

Amendment to the Lower Raritan/Middlesex County Water Quality Management Plan
Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (DEPE) is seeking public comment on a proposed amendment to the Lower Raritan/Middlesex County Water Quality Management (WQM) Plan. This amendment would adopt a Monroe Township Municipal Utilities Authority (MTMUA) Wastewater Management Plan. The planning area includes most of Monroe Township and two small areas presently served by MTMUA in Cranbury Township. The WMP, which was proposed by the Monroe Township Municipal Utilities Authority, provides for the expansion of the Middlesex County Utilities Authority sewer service area to include all of Monroe Township except the Jamesburg Training School for Boys which will continue to be served by its own on-site sewage treatment plant.

This notice is being given to inform the public that a plan amendment has been proposed for the Lower Raritan/Middlesex County WQM Plan. All information related to the WQM Plan and the proposed amendment is located at the Middlesex County Planning Board, 40 Livingston Avenue, New Brunswick, New Jersey 08901, and the NJDEPE, Office of Regulatory Policy, 401 East State Street, 3rd Floor, CN-029, Trenton, New Jersey 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 Middlesex County Planning Board at (908) 745-3016 or the Office of Regulatory Policy at (609) 633-7021.

Middlesex County will hold **a public hearing** on the proposed WQM Plan amendment. The public hearing will be on February 20, 1992, at 8:00 P.M., in the Freeholders' Meeting Room, 11th Floor, of the Middlesex County Administration Building located on John F. Kennedy Square, New Brunswick, New Jersey. **Interested persons** may submit written comments on the amendment to Mr. William J. Kruse of the Middlesex County Planning Board at the County Planning Board address cited above and a copy to Mr. Ed Frankel, Office of Regulatory Policy, at the NJDEPE address cited above. All comments must be submitted within 15 days following the public hearing. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by the County Board of Chosen Freeholders with respect to this amendment request. In addition, if the amendment is adopted by Middlesex County, the NJDEPE must review the amendment prior to final adoption. The comments received in reply to this notice and to the public hearing will also be considered by the NJDEPE during its review. Middlesex County and the NJDEPE thereafter may approve and adopt this amendment without further notice.

(c)

OFFICE OF REGULATORY POLICY

Amendment to the Lower Delaware Water Quality Management Plan
Public Notice

Take notice that on October 31, 1991, pursuant to the provisions of the 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 Lower Delaware Water Quality Management (WQM) Plan was adopted by the Department. The amendment was proposed by the Hopewell Township Board of Education for the Hopewell Township Crest School. This amendment identifies an expansion of the Hopewell Township Crest School on-site groundwater disposal system to serve a proposed 20,702 square foot addition. The school is located on Block 35, Lot 2, Hopewell Township, Cumberland County. The proposed school expansion will bring the total school population to 430 students and staff.

This amendment was noticed in the New Jersey Register on July 15, 1991. Comments on this amendment were received during the public comment period and are summarized below with the Department's responses.

COMMENT: The proposed on-site groundwater disposal system expansion is located within an identified future sewer service area in the Cumberland County Utilities Authority (CCUA) Wastewater Management Plan (WMP). The CCUA will require connection to the sanitary sewer system when service is available to this area.

RESPONSE: The CCUA WMP has not yet been submitted to the Department for review or approval, moreover, identification of a groundwater disposal system in a future sewer service area is not prohibited. The Hopewell Township Crest School presently lies within the district of the CCUA, however, it is not identified as a future sewer service area of the CCUA. Adoption of this amendment will not preclude the Hopewell Township Crest School from being located within the areas proposed for future sewer service by the CCUA in the CCUA WMP. Further, sewer service to this school can only be required upon adoption of the CCUA WMP or other appropriate amendment to the Lower Delaware WQM Plan.

(a)

OFFICE OF REGULATORY POLICY

Amendment to the Tri-County Water Quality Management Plan
Public Notice

Take notice that on November 6, 1991, pursuant to the provisions of the 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 Tri-County Water Quality Management Plan (WQM) was adopted by the Department. The amendment was proposed by the Mount Holly Sewerage Authority. This amendment adopts the Mount Holly Sewerage Authority (MHSA) Wastewater Management Plan (WMP) and updates a small portion of the Willingboro Municipal Utilities Authority (WMUA) WMP. The MHSA WMP expands the sewer service area of the MHSA sewage treatment plant (STP) in Eastampton, Hainesport, Mount Holly, Lumberton and Westampton Townships. Two parcels in the WMUA sewer service area in Westampton Township were transferred into the sewer service area of the MHSA STP. In addition, the WMP provides for a wastewater flow of 6.93 million gallons per day for the MHSA STP to serve the expanded sewer service areas. A small parcel in Eastampton Township along Smithville-Jacksonville Road has been removed from the MHSA STP sewer service area. Parcels in Eastampton, Hainesport, and Westampton Townships, not in the MHSA STP future sewer service area, will remain designated as areas of individual subsurface sewage disposal systems less than 2,000 gallons per day (GPD). A large portion of Lumberton Township will also remain designated as an area of individual subsurface sewage disposal systems less than 2,000 GPD. One industrial area in Lumberton Township has been designated as an area of subsurface sewage disposal systems less than 20,000 GPD.

(b)

OFFICE OF REGULATORY POLICY

Amendment to the Lower Delaware Water Quality Management Plan
Public Notice

Take notice that on November 18, 1991, pursuant to the provisions of the 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 Lower Delaware Water Quality Management (WQM) Plan was adopted by the Department. The amendment was proposed by the BF Goodrich Company. This amendment identifies an expansion to the existing BF Goodrich wastewater treatment facility (WTF) to serve the proposed Pedricktown Cogeneration Limited Partnership (PCLP) facility located on BF Goodrich property at Block 38, Lot 3 of Oldmans Township, Salem County. The existing industrial WTF has a design capacity of 0.8 million gallons per day (MGD) with a discharge outfall to an unnamed stormwater drainage ditch which flows through an Army Corps of Engineers drainage canal to the Delaware River. The amendment identifies an industrial WTF expansion to 2.1 MGD to serve the proposed PCLP facility, and redirects the WTF discharge outfall to a 12 inch pipeline going directly from BF Goodrich to the Delaware River.

(c)

OFFICE OF REGULATORY POLICY

Amendment to the Upper Delaware Water Quality Management Plan
Public Notice

Take notice that the New Jersey Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Upper Delaware Water Quality Management (WQM) Plan. This amendment, which was submitted by the Harmony Township Board of Education, proposes a new wastewater treatment facility utilizing groundwater disposal to serve the Harmony Elementary School. The facility will be sized to accommodate wastewater flow from 600 persons. The three existing on-site disposal systems will be abandoned and all flows conveyed to the new treatment facility. When, in the future, service becomes available to the Brainards/Buck Horn Creek Sewage Treatment Plant (STP) the school will connect to the STP.

This notice is being given to inform the public that a plan amendment has been proposed for the Upper Delaware WQM Plan. All information dealing with the aforesaid WQM Plan and the proposed amendment is located at the NJDEPE, Office of Regulatory Policy, 3rd Floor, 401 East State Street, CN-029, Trenton, New Jersey 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 Regulatory Policy at (609) 633-7021.

Interested persons may submit written comments on the proposed amendment to Mr. Ed Frankel, Office of Regulatory Policy, at the NJDEPE address cited above with a copy sent to Mr. Kevin Page, Johnson Engineering Incorporated, PO Box 1519, Morristown, New Jersey 07962. All comments must be submitted within 10 working 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 NJDEPE with respect to the amendment request.

Any interested person may request in writing that NJDEPE 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 ten working days of this public notice to Mr. Ed Frankel at the NJDEPE address cited above. If a public hearing is held, the public comment period in this notice shall be extended to close 15 days after the public hearing.

(d)

OFFICE OF REGULATORY POLICY

Amendment to the Upper Raritan Water Quality Management Plan
Public Notice

Take notice that on December 3, 1991, pursuant to the provisions of the 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 Upper Raritan Water Quality Management Plan was adopted by the Department. This amendment, submitted by Readington-Lebanon Sewerage Authority (RLSA), adopts a Wastewater Management Plan (WMP) for the RLSA. The WMP identifies: an expansion of the RLSA sewage treatment plant to accommodate wastewater flows of 1.453 million gallons per day; reduction of the Readington-Whitehouse and Three Bridges Sewer Service Areas; expansion of the Raritan Township Municipal Utilities Authority service area to include the Hedgerow Estates and Park Lane Estates developments; several on-site groundwater disposal facilities with design flows of less than 20,000 gallons per day; two surface irrigation effluent facilities; and the use of wastewate treatment and recycling facilities.

This amendment proposal was noticed in the New Jersey Register on July 15, 1991. Comments on this amendment were received during the public comment period and are summarized below with the Department's responses.

COMMENT: Commenter objects to the limiting of the Lebanon Borough sewer service area to the municipal boundaries of the Borough. The commenter, whose client has property both in Lebanon Borough and adjacent to this in Clinton Township, wishes both tracts of land to be sewered through Lebanon Borough. He contends that the selection and limitation of the sewer service area consistent with the municipal boundary is arbitrary and without factual basis.

RESPONSE: The Borough has demonstrated a future need for the additional capacity within the Borough. Additionally, the Borough, or the RLSA, is not required to provide sewer service beyond its area of responsibility. The commenter's client presently has a commercial building on the Lebanon Borough tract and thus reasonable use is being made of the Lebanon lot. If in the future it is found that Lebanon Borough has excess capacity available, it may be possible for the commenter and the Borough to negotiate an agreement for capacity. At such a time an amendment to the WMP could be proposed.

COMMENT: Commenter contends the R.O.M.—2 zoned area was included in the original 201 Service Area and that it is ludicrous to extract

this area along Route 22, which is at the perimeter of the amended extent of sewer service, from the RLSA sewer service area. An industrial zoned area requires sewers by its nature, whenever and wherever available.

RESPONSE: The RLSA sewer service area is being reduced due to limited capacity at the sewerage treatment plant even in light of the proposed expansion. The area of concern was included in the 201 Facilities Plan Study/Sewer Area but it was not included in the sewer service area which received federal funding. The R.O.M.—2 district is intended to permit the development of research, office, and manufacturing park uses. The WMP allows for the use of on-site groundwater disposal facilities of design capacity less than 20,000 gallons per day in this area. In general, the intended uses can be accommodated by such facilities pending site specific and technical review. If in the future it is found that RLSA has capacity available it may be possible for this area to be included in the sewer service area. At such time an amendment to the WMP could be proposed.

HEALTH

(a)

THE COMMISSIONER

Availability of Grants
Directory of Department of Health Grant Programs

Take notice that, in compliance with N.J.S.A. 52:14-34.4 et seq. (P.L.1987, c.7), the Department of Health hereby publishes notice of grant availability in the Directory of Department of Health Grant Programs. Copies of the Directory can be obtained by contacting the Grant Evaluation and Review Program, Office of Financial and General Services, Department of Health at 609-588-7448.

HUMAN SERVICES

(b)

GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT

Notice of Availability of Grant Funds
Children's Justice Act Grants

Take notice that, in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Governor's Task Force on Child Abuse and Neglect hereby announces the availability of the following grant program funds.

A. Name of program: Children's Justice Act Grants.

B. Purpose: The Governor's Task Force on Child Abuse and Neglect was created by Executive Order to coordinate and facilitate the development of Statewide community education, prevention programs, and child protection. The Task Force members are professionals from the discipline of law, medicine, education, social services, and private enterprise.

C. Amount of available funding for the program: The amount of money available is $156,994. Grant awards may range from $5,000 to $100,000.

D. Organizations which may apply for funding under this program: Public or private nonprofit agencies with 501(c)3 status may apply. Documentation of this status is required in the application.

E. Qualifications needed by an applicant to be considered for funding: Recipients of Children's Justice Act Grants shall use the grant funds to: develop and implement innovative programs designed to improve (1) the handling of child abuse cases, particularly child sexual abuse, in a manner which limits additional trauma to the child victim, and (2) the investigation and prosecution of cases of child abuse, particularly child sexual abuse. Examples are: experimental, model and demonstration programs including multidisciplinary management teams specially trained to handle the investigation, treatment, and prosecution of child abuse cases.

If the applicant is a recipient of other Federal funds, grants from the Governor's Task Force may not be used to meet the non-Federal matching requirement of Federal law.

F. Procedure for eligible organizations to apply: All eligible organizations interested in applying should obtain directions (RFP) and an application by calling the Governor's Task Force at (609) 292-0888, Monday through Friday, 9:00 A.M. to 5:00 P.M., or by writing to the Governor's Task Force, CN 700, Trenton, NJ 08625. Applications will be available commencing December 16, 1991 and will be accepted through February 17, 1992.

G. Address to which applications must be submitted:
Governor's Task Force on Child Abuse and Neglect
CN 700
Trenton, NJ 08625-0700

H. Deadline by which applications must be submitted: February 17, 1992.

I. Date the applicant is to be notified of acceptance or rejection: April 15, 1992.

(c)

DIVISION OF YOUTH AND FAMILY SERVICES

Notice of Availability of Grant Funds
Wrap Around/Family Support Services—FY '92 State Aid
Semi-Supervised Independent Living Program for Aging Out Youth

Take notice that in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Department of Human Services announces the following availability of funds:

A. Name of grant program: Semi-Supervised Independent Living Program for Aging Out Youth.

B. Purpose for which the grant program funds shall be used: This program will provide semi-supervised independent living for six males (ages 17-19) being serviced by the Warren, Sussex, and Morris District Offices of the Division of Youth and Family Services who are in need of skills to enable them to successfully live independently in their community.

C. Amount of money in the grant program: Funding in the amount of $120,000 in State Aid funds is available for this program. This funding will be continuous. There are no matching funds required.

D. Organizations which may apply for funding under this program: Public or private not-for-profit social service agencies serving Warren, Sussex, and Morris counties.

E. Qualifications needed by an applicant to be considered for funding: Applicants shall have experience operating a supervised independent living program, group home, residential treatment center or other similar program and shall be familiar with the social services required by the targeted population.

F. Procedure for eligible organizations to apply: Agencies interested in applying for these funds should submit seven copies of the completed Request for Proposal to the address given below.

G. Address to which applications must be submitted: The completed RFP is to be returned to the New Jersey Division of Youth and Family Services, Northern Regional Office, 100 Hamilton Plaza—Room 710, Paterson, New Jersey 07505.

H. Deadline by which applications must be submitted: The completed application and all required supporting materials and copies must be received by the New Jersey Division of Youth and Family Services, Northern Regional Office, by 4:00 P.M. on February 18, 1992.

I. Date by which applicants shall be notified of acceptance or rejection: February 28, 1992.

(d)

DIVISION OF YOUTH AND FAMILY SERVICES

Notice of Availability of Grant Funds
Wrap Around/Family Support Services—FY '92 State Aid
Home Based Treatment Program for Children and Their Families

Take notice that in compliance with N.J.S.A. 52:14-34.4, 34.5 and 34.6, the Department of Human Services announces the following availability of funds:

A. Name of grant program: Home Based Treatment Program for Children and Their Families.

B. Purpose for which the grant program funds shall be used: This program is intended to enhance, strengthen and preserve family functioning, by establishing an intensive home based therapeutic intervention program for children, adolescents and their families in Sussex County, who are under the supervision of the Division of Youth and Family Services, and who are at risk of being separated or are in out-of-home placement.

C. Amount of money in the grant program: Funding in the amount of $135,000 in State Grant-in-Aid funds is available for this program. This funding will be continuous. There are no matching funds required.

D. Organizations which may apply for funding under this program: Public or private not-for-profit social service agencies serving Sussex County.

E. Qualifications needed by an applicant to be considered for funding: Applicants shall have experience operating a community based therapeutic intervention program or similar program for children at risk or in an out-of-home placement.

F. Procedure for eligible organizations to apply: Agencies interested in applying for these funds should submit seven copies of the completed Request for Proposal to the address given below.

G. Address to which applications must be submitted: The completed Request for Proposal is to be returned to the New Jersey Division of Youth and Family Services, Northern Regional Office, 100 Hamilton Plaza—Room 710, Paterson, New Jersey 07505.

H. Deadline by which applications must be submitted: The completed application and all required supporting materials and copies must be received by the New Jersey Division of Youth and Family Services, Northern Regional Office, by 4:00 P.M. on February 18, 1992.

I. Date by which applicants shall be notified of acceptance or rejection: February 28, 1992.

LAW AND PUBLIC SAFETY

(a)

OFFICE OF THE ATTORNEY GENERAL

Notice of the Availability of the Quarterly Report of Legislative Agents for the Third Quarter of 1991 ending September 30, 1991

Take notice that Robert J. Del Tufo, Attorney General of the State of New Jersey, in compliance with N.J.S.A. 52:13C-23(h), hereby publishes Notice of Availability of the Quarterly Report of Legislative Agents for the Third Quarter of 1991, accompanied by a Summary of the Quarterly Report.

At the conclusion of the Third Quarter of 1991, the Notices of Representation filed with this office reflect that 559 individuals are registered as Legislative Agents. Legislative Agents are required by law to submit in writing a quarterly report of their activity in attempting to influence legislation during each calendar quarter. The aforesaid report shall be filed between the first and tenth days of each calendar quarter for such activity that occurred during the preceding calendar quarter. (N.J.S.A. 52:13C-22(b)).

A complete quarterly report of Legislative Agents, consisting of the summary and copies of all quarterly reports filed by Legislative Agents for the Third Calendar Quarter of 1991, has been filed separately for reference with the following offices: the Office of the Governor, the Office of the Attorney General, the Office of Legislative Services (Bill Room), the Office of Administrative Law, and the State Library. Each is available for inspection in accordance with the practices of those offices.

The Summary Report includes the following information:

—The names of registered Agents, their registration numbers, their business addresses and whom they represent.

—A list of Agents who have filed quarterly reports by statutory and compilation deadlines for this quarter.

—A list of Agents whose quarterly reports were not received by the compilation deadline for this quarter.

Following is a listing of all new Legislative Agents who have filed Notices of Representation during the Third Calendar Quarter of 1991:

No. 27 Dorothy J. Dunfee representing League of Women Voters of NJ

No. 45 Ernest Landante, Jr. representing NJ Savings League

No. 53 Carol Ann Giancarli representing NJ Builders Assn.

No. 144 Deborah T. Poritz representing Jamieson Moore Peskin & Spicer and State Farm Insurance Co.

No. 155 JoAnn D. Bartoletti representing NJ Principals & Supervisors Assn.

No. 173 Mark W. Musser representing Riker Danzig Scherer Hyland & Perretti

No. 381 Morton Goldfein representing Waters McPherson McNeill PA & Tropicana Products

No. 394 Dr. Jack Eisenstein representing NJ Assn. of School Administrators

No. 551 William J. Palatucci representing MWW Strategic Communications Inc.

No. 567 Penni E. Wild representing The Lindemann Concern

No. 689 Joan O'Brien representing NJ Conference of Mayors

No. 690 John Markert representing John Markert Associates

No. 691 Kenneth J. Smith representing Coastal Advocate

No. 692 Patrick W. Breslin representing NJ Manufacturers Insurance Co.

No. 693 John J. O'Brien representing NJ Press Assn.

No. 694 Thomas W. Kelly representing NJ Food Council

No. 695 Glen Weinberg representing Washington Resources Ltd.

No. 696 Samuel Cozzo representing Washington Resources Ltd.

No. 697 Frank DeMaria representing NJ Industrial Union Council AFL-CIO

No. 698 Sarah A. Phillips representing Alliance of American Insurers

No. 699 E. John Cucci representing Alliance of American Insurers

No. 700 Jill I. Cappiello representing NJ Chiropractic Society

No. 701 Mark D. Feinberg representing Kidder Peabody

No. 702 Jeri J. Colombaro representing IBM Corp.

No. 703 S. Thomas Gagliano representing Giordano Halleran & Ciesla and Metro Newark Chamber of Commerce

No. 704 Michael J. Gross representing Giordano Halleran & Ciesla, NJ Builders Assn. and NJ Shore Builders Assn.

No. 705 Donald M. Scarry representing Giordano Halleran & Ciesla and Hazardous Waste Treatment Council

No. 706 George J. Tyler representing Giordano Halleran & Ciesla and Hazardous Waste Treatment Council

No. 707 Philip H. Roberts representing NJ Broadcasters Assn.

No. 708 Kathleen K. Kositzky representing Justice Fellowship

No. 709 Phyllis A. Matthey representing CAPA (Coalition of Associations for Political Action)

No. 710 William H. Baxter representing Johnson & Johnson

No. 711 Virginia Austenberg representing Humane Society of the US

No. 712 Robert T. Reder representing Humane Society of the US

No. 713 William C. Faust, Jr. representing United Telephone Co of NJ Inc.

No. 714 Charles Donald Vogel representing State Farm Insurance Co.

No. 715 John J. Ross representing Lomurro Davison Eastman & Munoz

No. 716 Joseph S. Roth representing Schering-Plough Corp.

No. 717 Bernard Dziedzic representing Heavy & General Construction Laborers Local Union No. 472

No. 718 Richard Hyde representing Panhandle Eastern Corp.

No. 719 Barbara A. Curran representing Carella Byrne Bain Gilfillan Cecchi & Stewart, Community Energy Alternatives and Logan Vista

No. 720 John F. Malone representing Carella Byrne Bain Gilfillan Cecchi & Stewart, Community Energy Alternatives and Logan Vista

No. 721 Clark W. Martin and Paul N. Bontempo representing Martin-Bontempo Inc.

No. 722 Joseph Botte representing United Food & Commercial Workers Union AFL-CIO & CLC

Following is a listing of all Legislative Agents who have filed Notices of Termination during the Third Calendar Quarter of 1991:

Legislative Agent	Registration Number
Carol R. Katz	7
Therese A. Lowenthal	27
Marianne E. Rhodes	53
William Hobokan	171
Richard J. Kinney	293
Peter J. McDonough, Jr.	365
Harrison B. Slack	395
Judith Trachtenberg	398
Paul Bontempo	522
Mary Dowling	522

April Jackson	543
James T. Nelson	545
Kenneth C. LeFevre	578
Joseph S. Roth	599
Clark W. Martin	615
Jeffrey A. Warsh	623
Jeffrey Kaszerman	627
George VanAllen	635
Ruthi G. Zinn	647
Rosemarie Gnam	680

For further information contact the Legislative Agents Unit at (609) 984-9371.

TREASURY-TAXATION

(a)

DIVISION OF TAXATION

Petroleum Products Gross Receipts Tax
Notice of Tax Rate; January 1, 1992 through June 30, 1992

This notice is to advise petroleum products gross receipts taxpayers that for the period January 1, 1992 through June 30, 1992 the applicable tax rate for fuel oils, aviation fuels, and motor fuels, as converted to a cents per gallon rate pursuant to N.J.S.A. 54:15B-3 will be $0.04 per gallon. The rate is effective for tax due for months ending during that period and this rate remains unchanged from the per gallon rate effective during the prior six month period.

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 November 4, 1991 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 adoption of the rule and its chronological ranking in the Registry. As an example, R.1991 d.1 means the first rule adopted in 1991.

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 OCTOBER 21, 1991

NEXT UPDATE: SUPPLEMENT NOVEMBER 18, 1991

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
23 N.J.R. 1 and 144	January 7, 1991	23 N.J.R. 2079 and 2204	July 15, 1991
23 N.J.R. 145 and 248	January 22, 1991	23 N.J.R. 2205 and 2446	August 5, 1991
23 N.J.R. 249 and 332	February 4, 1991	23 N.J.R. 2447 and 2560	August 19, 1991
23 N.J.R. 333 and 636	February 19, 1991	23 N.J.R. 2561 and 2806	September 3, 1991
23 N.J.R. 637 and 798	March 4, 1991	23 N.J.R. 2807 and 2898	September 16, 1991
23 N.J.R. 799 and 924	March 18, 1991	23 N.J.R. 2899 and 3060	October 7, 1991
23 N.J.R. 925 and 1048	April 1, 1991	23 N.J.R. 3061 and 3192	October 21, 1991
23 N.J.R. 1049 and 1226	April 15, 1991	23 N.J.R. 3193 and 3402	November 4, 1991
23 N.J.R. 1227 and 1482	May 6, 1991	23 N.J.R. 3403 and 3548	November 18, 1991
23 N.J.R. 1483 and 1722	May 20, 1991	23 N.J.R. 3549 and 3678	December 2, 1991
23 N.J.R. 1723 and 1854	June 3, 1991	23 N.J.R. 3679 and 3840	December 16, 1991
23 N.J.R. 1855 and 1980	June 17, 1991	24 N.J.R. 1 and 164	January 6, 1992
23 N.J.R. 1981 and 2071	July 1, 1991		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:1-18.1	Initial decision in contested cases	23 N.J.R. 3406(a)		
1:13A-18.2	Lemon Law hearings: exception to initial decision	23 N.J.R. 3682(a)		
1:14	Board of Public Utility hearings: administrative change	_____	_____	23 N.J.R. 3647(a)
1:31-3	Discipline of administrative law judges	23 N.J.R. 2901(a)	R.1992 d.17	24 N.J.R. 87(a)
1:31-3	Discipline of administrative law judges: extension of comment period	23 N.J.R. 3179(a)		
	Most recent update to Title 1: TRANSMITTAL 1991-5 (supplement October 21, 1991)			
AGRICULTURE—TITLE 2				
	Most recent update to Title 2: TRANSMITTAL 1991-6 (supplement August 19, 1991)			
BANKING—TITLE 3				
3:1-16	Mortgage processing rules	23 N.J.R. 2613(b)		
3:1-19	Consumer checking accounts	23 N.J.R. 3682(b)		
3:6-4.5, 4.6	Banks and savings banks: reporting of crimes	23 N.J.R. 2903(a)		
3:13	Bank holding companies and interstate acquisitions	23 N.J.R. 2904(a)		
3:13	Bank holding companies and interstate acquisitions: extension of comment period	23 N.J.R. 3686(a)		
3:21	Credit unions	23 N.J.R. 3686(b)		
3:21-1	Low-income credit unions	23 N.J.R. 2905(a)		
3:21-1	Low-income credit unions: correction to comment period deadline	23 N.J.R. 3196(a)		
3:26-3.1, 3.2	Savings and loan associations: reporting of crimes	23 N.J.R. 2903(a)		
3:38-1.1, 1.9, 4.1, 5	Mortgage financing activities and real estate licensees	23 N.J.R. 3406(b)		
3:38-1.1, 1.9, 4.1, 5	Mortgage financing activities and real estate licensees: extension of comment period	23 N.J.R. 3686(c)		
3:38-1.2, 1.4, 1.9, 2.1	Mortgage banker and broker net worth standards	23 N.J.R. 2450(a)	R.1991 d.588	23 N.J.R. 3743(a)
	Most recent update to Title 3: TRANSMITTAL 1991-8 (supplement October 21, 1991)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1990-3 (supplement July 16, 1990)			
PERSONNEL—TITLE 4A				
4A:2-2.13	Expungement from personnel files of references to disciplinary action	23 N.J.R. 2906(a)		
4A:4-2.16	Inspection of examination scoring keys	23 N.J.R. 2906(b)		
4A:4-7.10, 7.12	Reinstatement following disability retirement	23 N.J.R. 2907(a)		
4A:4-7.11	Retention of rights by transferred employees	23 N.J.R. 1984(b)		
4A:6-1.6	Sick Leave Injury (SLI): State service	23 N.J.R. 2907(b)		
4A:6-1.6	Sick Leave Injury (SLI): withdrawal of proposal	23 N.J.R. 3093(a)		
	Most recent update to Title 4A: TRANSMITTAL 1991-3 (supplement October 21, 1991)			
COMMUNITY AFFAIRS—TITLE 5				
5:12-2.1	Homelessness Prevention Program: eligibility	23 N.J.R. 3439(a)		
5:14-1.1–1.6, 2.1, 2.2, 2.3, 3.1–3.12, 3A, 4.10, App. A–D	Neighborhood Preservation Balanced Housing Program	23 N.J.R. 1075(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
5:18-1.1, 1.5, 2.4A, 2.6, 2.9, 4.1, 4.7, 4.11, 4.17	Uniform Fire Code: compliance and enforcement	23 N.J.R. 3552(a)		
5:18-1.4	Uniform Fire Code: applicability of requirements	23 N.J.R. 2813(a)	R.1991 d.570	23 N.J.R. 3444(a)
5:18-2.4A, 2.4B, 2.7	Uniform Fire Code: life hazard uses; permits	23 N.J.R. 2999(a)		
5:18-2.8	Uniform Fire Code: registration and permit fees	23 N.J.R. 2999(a)	R.1991 d.530	23 N.J.R. 3325(a)
5:18-2.8, 2.20, 3.2, 4.3, 4.19	Uniform Fire Code: smoke detector compliance in one and two-family dwellings	23 N.J.R. 3064(a)	R.1992 d.11	24 N.J.R. 88(a)
5:18-2.19	Uniform Fire Code: identifying emblems for structures with truss construction	23 N.J.R. 2618(a)	R.1992 d.5	24 N.J.R. 89(a)
5:18-3	State Fire Prevention Code	23 N.J.R. 3554(a)		
5:18A-2.6	Fire Code Enforcement: collection of fees	23 N.J.R. 3552(a)		
5:18C-4.2	Firefighter I certification	23 N.J.R. 2084(a)		
5:23-3.8A, 3.15	Uniform Construction Code: sale of nonconforming toilets	23 N.J.R. 3602(a)		
5:23-3.15, 3.21	Uniform Construction Code: plumbing; one and two family dwelling subcodes	23 N.J.R. 2619(a)	R.1991 d.571	23 N.J.R. 3444(b)
5:23-3.21	UCC: one and two family dwelling subcode	23 N.J.R. 3444(b)		
5:23-4.5, 4.19	Uniform Construction Code: electronic reporting by municipal enforcing agencies	23 N.J.R. 3440(a)		
5:23-4.14, 4A.17, 8.18	Uniform Construction Code: pre-proposal regarding private enforcing agencies	23 N.J.R. 1985(a)		
5:23-4.14, 4A.17, 8.18	Uniform Construction Code: preproposal regarding private enforcing agencies	23 N.J.R. 2908(a)		
5:23-5.25	Uniform Construction Code: revocation of licenses and alternative sanctions; review committees	23 N.J.R. 3441(a)		
5:23-7.6A	Barrier-Free Subcode enforcement	23 N.J.R. 2620(a)	R.1991 d.561	23 N.J.R. 3445(a)
5:23-10, App. 10-A	Radon Hazard Subcode: tier I municipalities	_____	_____	23 N.J.R. 3745(a)
5:23-11	Uniform Construction Code: Indoor Air Quality Subcode	23 N.J.R. 1730(b)		
5:23-12.2	Elevator Safety Subcode: referenced standards	23 N.J.R. 2046(a)		
5:25-1.3	New home warranties: "major structural defect"	23 N.J.R. 3603(a)		
5:25A	Fire retardant treated (FRT) plywood roof sheathing failures: alternative claim procedures	23 N.J.R. 3603(a)		
5:33-4	Property tax and mortgage escrow account transactions	23 N.J.R. 1903(a)		
5:80-29	Housing and Mortgage Finance Agency: investment of surplus funds	23 N.J.R. 2621(a)		
5:80-30	Housing and Mortgage Finance Agency: residual receipts	23 N.J.R. 3733(a)		
5:80-31	Housing and Mortgage Finance Agency: attorney services	23 N.J.R. 2622(a)		
5:91-15	Council on Affordable Housing: municipal development fees	23 N.J.R. 2813(b)		
5:91-15	Council on Affordable Housing: public hearing and extension of comment period regarding municipal development fees	23 N.J.R. 3132(a)		
5:92	Council on Affordable Housing: preproposal regarding mandatory developers' fees	23 N.J.R. 646(b)		
5:92-1.3, 1.4, 8.4, 18	Council on Affordable Housing: municipal development fees	23 N.J.R. 2813(b)		
5:92-1.3, 1.4, 8.4, 18	Council on Affordable Housing: public hearing and extension of comment period regarding municipal development fees	23 N.J.R. 3132(a)		
5:92-1.6	Council on Affordable Housing: interim substantive certification	23 N.J.R. 3253(a)		

Most recent update to Title 5: TRANSMITTAL 1991-10 (supplement October 21, 1991)

MILITARY AND VETERANS' AFFAIRS (formerly DEFENSE)—TITLE 5A

5A:3	Military service medals	23 N.J.R. 1490(a)		
5A:3-1, 2	Military service medals: reopening of comment period	23 N.J.R. 3409(a)		
5A:4	Brigadier General William C. Doyle Veterans' Memorial Cemetery	23 N.J.R. 1491(a)		
5A:4	Brigadier General William C. Doyle Veterans' Memorial Cemetery: reopening of comment period	23 N.J.R. 3254(a)		

Most recent update to Title 5A: TRANSMITTAL 1990-2 (supplement June 18, 1990)

EDUCATION—TITLE 6

6:5-2	Organization of Department	Exempt	R.1992 d.21	24 N.J.R. 90(a)
6:8	Thorough and efficient system of schools	23 N.J.R. 2908(b)	R.1992 d.22	24 N.J.R. 90(b)
6:8-1.1, 6.1, 6.2, 6.3	Preventive and remedial programs in reading, writing and mathematics	23 N.J.R. 2085(a)		
6:11-6.2	Early childhood instructional certificate	23 N.J.R. 2210(b)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
6:20-2.13, 2A.11, 3.1, 3.3, 3.4, 5.8	Free balance and restricted appropriations; tuition rates for regular public and county schools; excess surplus calculation	23 N.J.R. 2818(a)	R.1991 d.590	23 N.J.R. 3746(a)
	Most recent update to Title 6: TRANSMITTAL 1991-8 (supplement September 16, 1991)			
ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
7:1 et al.	Centralized filing of requests for adjudicatory hearings: administrative changes	———	———	23 N.J.R. 3325(b)
7:1-1.3, 1.4	Delegations of authority within the Department	23 N.J.R. 3276(a)		
7:1-2	Third-party appeals of permit decisions	23 N.J.R. 3278(a)		
7:1E-1.6, 1.9, 7, 8, 9, 10	Discharges of petroleum and other hazardous substances: confidentiality of information	23 N.J.R. 2848(a)		
7:1H	County environmental health standards: request for public input concerning amendments to N.J.A.C. 7:1H	23 N.J.R. 2237(a)		
7:1I-3.3	Sanitary Landfill Facility Contingency Fund: suspension of claims	22 N.J.R. 3675(a)	R.1991 d.582	23 N.J.R. 3647(b)
7:2-11.3–11.9, 11.12–11.14	Natural Areas and Natural Areas System	23 N.J.R. 1985(b)		
7:4	New Jersey Register of Historic Places: procedures for listing of historic places	23 N.J.R. 2103(a)		
7:7-4.5, 4.6	Coastal Permit Program: public hearings; final review of applications	23 N.J.R. 3280(a)		
7:7A	Freshwater Wetlands Protection Act rules: water quality certification	23 N.J.R. 338(a)		
7:9-5.8	Water pollution control: minimum treatment requirements	23 N.J.R. 1493(a)		
7:9-6	Ground water quality standards: request for comment on draft revisions	23 N.J.R. 1988(a)		
7:11-2.2, 2.3, 2.9	Sale of water from Delaware and Raritan Canal and Spruce Run/Round Valley Reservoirs System	23 N.J.R. 3686(d)		
7:11-4.3, 4.4, 4.9, 4.13	Sale of water from Manasquan Reservoir Water Supply System	23 N.J.R. 3688(a)		
7:12-1.1, 2.1, 3.2, 4.1, 4.2, 7.1, 9.8, 9.10	Shellfish growing water classification	23 N.J.R. 2993(a)	R.1991 d.592	23 N.J.R. 3751(a)
7:13	Flood hazard area control: opportunity to comment on draft revisions	23 N.J.R. 1989(a)		
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7:13-7.1	Redelineation of South Branch Raritan River in Hunterdon County	23 N.J.R. 647(b)		
7:13-7.1	Redelineation of Passaic River in Florham Park	23 N.J.R. 648(a)	R.1991 d.568	23 N.J.R. 3446(a)
7:13-7.1	Redelineation of Lawrence and Heathcote Brooks in South Brunswick	23 N.J.R. 649(a)	R.1991 d.569	23 N.J.R. 3446(b)
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7:25-18.1	Taking of Atlantic sturgeon: preproposed amendment	23 N.J.R. 1111(a)		
7:25-18.1, 18.12, 18.13	Weakfish management program	23 N.J.R. 1989(b)		
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7:26-2.4	Small scale solid waste facility permits: request for comment on draft revisions to N.J.A.C. 7:26-2.4	23 N.J.R. 2458(a)		
7:26-4.6	Solid waste program fees	23 N.J.R. 3690(a)		
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7:26-7.7, 8.2, 8.3, 8.4, 8.20, 9.1	PCB hazardous waste	23 N.J.R. 2855(a)		
7:26-8.2	Hazardous waste exclusions: household waste	23 N.J.R. 3410(a)		
7:26-8.2	Hazardous waste exclusions: used chlorofluorocarbon refrigerants	23 N.J.R. 3692(a)		
7:26-8.16	Hazardous constituents in waste streams	23 N.J.R. 3093(b)		
7:26-9.2, 10.6, 10.8, 11.3, 11.4, 12.2, 12.4	Hazardous waste management	22 N.J.R. 3186(a)	R.1991 d.562	23 N.J.R. 3450(a)
7:26A	Solid waste recycling	22 N.J.R. 3088(a)	R.1991 d.529	23 N.J.R. 3452(a)
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7:27B-3.1, 3.2, 3.4–3.12, 3.14, 3.15, 3.17, 3.18	Air pollution by volatile organic comounds: sampling and analytical procedures	23 N.J.R. 1858(b)		
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7:28-1.4, 20	Particle accelerators for industrial and research use	23 N.J.R. 1401(c)		
7:50-2.11, 4.61–4.70, 5.27, 5.28, 5.30, 5.32, 6.13	Pinelands Comprehensive Management Plan: waivers of strict compliance	23 N.J.R. 2458(b)		
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8:21A	Good drug manufacturing practices: reopening of comment period	23 N.J.R. 1252(a)		
8:31A-1.1, 2.6, 7.4, 7.5, App. A, D	SHARE Manual: patient day add-on; EDR and OPPM cost centers	23 N.J.R. 2242(a)	R.1991 d.580	23 N.J.R. 3648(a)
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8:31B-3.73	Hospital rate setting: correction to proposed amendment and extension of comment period	23 N.J.R. 3442(a)		
8:31B-5.3	Hospital reimbursement: Diagnosis Related Groups	23 N.J.R. 3114(a)		
8:31C-1	Residential alcoholism treatment facilities: cost accounting and rate evaluation	23 N.J.R. 3609(a)		
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8:40	Invalid coach and ambulance services	23 N.J.R. 2566(a)	R.1992 d.16	24 N.J.R. 119(a)
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8:43-4.7, 4.15, 4.16, 7.2	Residential health care facilities: patient advance directives	23 N.J.R. 3616(a)		
8:43E-3.10, 3.15	Adult closed acute psychiatric beds: liaison participation and discharge planning	23 N.J.R. 3128(a)		
8:43G-4.1, 5.2, 5.3, 5.5, 5.7, 5.9, 5.12, 5.16, 5.18, 7.5, 7.16, 7.22, 7.23, 7.24, 7.26, 7.28, 7.32, 7.33, 7.34, 7.37, 7.40, 8.4, 8.7, 8.11, 9.7, 9.14, 9.19, 10.1, 10.4, 11.5, 12.2, 12.3, 12.7, 12.10, 13.4, 13.13, 14.1, 14.9, 15.2, 15.3, 16.1, 16.2, 16.6, 16.7, 18.4–18.7, 19.2, 19.5, 19.13, 19.14, 19.15, 19.17, 19.18, 19.22, 19.23, 19.33, 20.1, 20.2, 22.2, 22.3, 22.12, 22.17, 22.20, 23.1, 23.2, 23.6, 24.9, 24.13, 25.1, 26.2, 26.3, 26.9, 28.1, 28.8, 28.10, 29.13, 29.17, 30.1, 30.2, 30.3, 30.5, 30.6, 30.8, 30.11, 32.3, 32.5, 32.9, 32.12, 33.6, 35.2	Hospital licensing standards	23 N.J.R. 2590(a)		
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8:61	AIDS prevention and control	23 N.J.R. 2245(b)	R.1991 d.538	23 N.J.R. 3332(a)
8:61	AIDS prevention and control: extension of comment period	23 N.J.R. 2882(e)		
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8:61-2	Participation in AIDS Drug Distribution Program: extension of comment period	23 N.J.R. 2883(a)		
8:65-2.4, 2.5, 6.6, 6.13, 6.16	Controlled dangerous substances: handling of carfentanil, etorphine hydrochloride, and diprenorphine	23 N.J.R. 1911(a)		
8:65-7.5, 7.10	Controlled dangerous substances: partial filling of prescriptions for Schedule II substances	23 N.J.R. 3618(a)		
8:66	Alcohol countermeasures: waiver of expiration provision of Executive Order No. 66(1978)	23 N.J.R. 177(a)		
8:71	Interchangeable drug products (see 23 N.J.R. 1670(a), 2136(a), 2783(a))	23 N.J.R. 178(a)	R.1991 d.560	23 N.J.R. 3337(a)
8:71	Interchangeable drug products	23 N.J.R. 1509(a)	R.1992 d.26	24 N.J.R. 145(a)
8:71	Interchangeable drug products	23 N.J.R. 2610(a)	R.1992 d.25	24 N.J.R. 144(b)
8:71	Interchangeable drug products	23 N.J.R. 3258(a)	R.1992 d.27	24 N.J.R. 145(b)
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10:16	Child Death and Critical Incident Review Board concerning children under DYFS supervision	23 N.J.R. 3417(a)		
10:50	Transportation Services Manual	23 N.J.R. 3619(a)		
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10:51-1.1, 1.14, 3.3, 3.12	Bundled drug services	23 N.J.R. 281(a)		
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10:53-1.1, 1.17	Bundled drug services	23 N.J.R. 281(a)		
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10:66-1.2, 1.10	Bundled drug services	23 N.J.R. 281(a)		
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10:69-5.1	HAAAD: income eligibility limits	23 N.J.R. 2623(a)	R.1991 d.563	23 N.J.R. 3514(a)
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10:69B-4.2	Lifeline Credit Program: income eligibility limits	23 N.J.R. 2623(a)	R.1991 d.563	23 N.J.R. 3514(a)
10:69B-4.8	Lifeline Programs: submission date for utility assistance eligibility applications	23 N.J.R. 3267(a)		
10:72-6.1–6.5	New Jersey Care: presumptive eligibility process for pregnant women	23 N.J.R. 2827(a)	R.1992 d.10	24 N.J.R. 100(a)
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10:81-14.12, 14.18	Public Assistance Manual: child care payment for AFDC families in REACH/JOBS program	23 N.J.R. 2214(a)	R.1991 d.555	23 N.J.R. 3365(a)
10:81-14.18, 14.18A, 14.18B	REACH child care co-payment	23 N.J.R. 2981(a)	R.1991 d.601	23 N.J.R. 3791(a)
10:81-15	Child Care Plus Demonstration	23 N.J.R. 8(a)		
10:82-1.1A	AFDC Standard of Need	23 N.J.R. 285(a)	R.1992 d.1	24 N.J.R. 101(a)
10:82-1.1A	AFDC Standard of Need: public hearings and extension of comment period	23 N.J.R. 967(a)		
10:82-2.8, 4.4, 5.3	Assistance Standards Handbook: child care payment for AFDC families in REACH/JOBS program	23 N.J.R. 2217(a)	R.1991 d.556	23 N.J.R. 3366(a)
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10:82-4.9	Assistance Standards Handbook: DYFS monthly foster care rates	23 N.J.R. 3420(a)		
10:82-5.3	REACH child care voucher rates	23 N.J.R. 2989(a)		
10:84-1	Efficiency and effectiveness of program operations	23 N.J.R. 1740(a)		
10:84-1	Efficiency and effectiveness of program operations: public hearing and extension of comment period	23 N.J.R. 2220(b)		
10:85-4.1	General Assistance Program: Standard of Need	23 N.J.R. 286(a)	R.1992 d.2	24 N.J.R. 103(a)
10:85-4.1	General Assistance Standard of Need: public hearings and extension of comment period	23 N.J.R. 967(a)		
10:120-1.2	Youth and Family Services: scope of responsibilities and services	23 N.J.R. 3420(b)		
10:122B	Division of Youth and Family Services: requirements for foster care	23 N.J.R. 3693(a)		
10:122C	DYFS: approval of foster homes	23 N.J.R. 3696(a)		
10:122D	DYFS: foster care services	23 N.J.R. 3703(a)		
10:122E	DYFS: removal of foster children and closure of foster homes	23 N.J.R. 3708(a)		
10:123A	Youth and Family Services: Personal Attendant Services Program	23 N.J.R. 2091(b)		
10:132	Youth and Family Services: court actions and procedures	23 N.J.R. 2099(a)	R.1991 d.576	23 N.J.R. 3651(b)
10:133	DYFS: initial response and service delivery	23 N.J.R. 3714(a)		
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10A:9	Inmate classification process	23 N.J.R. 3721(a)		
10A:10-3	Interstate Corrections Compact	23 N.J.R. 2221(a)	R.1991 d.586	23 N.J.R. 3756(b)
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10A:18-2.9	Identification of inmate outgoing correspondence	23 N.J.R. 2468(a)	R.1992 d.3	24 N.J.R. 107(a)
10A:20-4	Residential Community Release Agreement Programs for adult inmates	23 N.J.R. 3624(a)		
10A:22-2.6	Availability of medical information to inmates	23 N.J.R. 3424(a)		
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11:3-40	Insurers required to provide automobile coverage to eligible persons	23 N.J.R. 3736(a)		
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11:3-43	Private passenger automobile insurance: personal lines rating plans	23 N.J.R. 3221(a)		
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11:5-1.38–1.42	Real Estate Commission: dual agency for dual compensation practices; kickbacks for referrals; written disclosures; exclusion of outside mortgage lenders	23 N.J.R. 3424(b)		
11:5-1.38–1.42	Real Estate Commission: extension of comment period regarding dual agency for dual compensation practices; kickbacks for referrals; written disclosures; exclusion of outside mortgage lenders	23 N.J.R. 3739(b)		
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11:17A-1.3	Licensure of insurance producers and limited insurance representatives	23 N.J.R. 1912(a)		
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12:51	Vocational Rehabilitation Services: waiver of expiration provision of Executive Order No. 66(1978)	23 N.J.R. 1893(a)		
12:51	Vocational Rehabilitation Services	23 N.J.R. 2927(a)	R.1991 d.604	23 N.J.R. 3797(a)
12:55	Wage payments	23 N.J.R. 2939(a)	R.1991 d.605	23 N.J.R. 3807(a)
12:56-1.2–1.6	Wage and hour violations, administrative penalties and fees, hearings, and employer offenses	23 N.J.R. 2942(a)	R.1991 d.606	23 N.J.R. 3810(a)
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12:60-2.1, 6.1	Public works employers: inspection of payroll records	23 N.J.R. 2945(a)		
12:60-9	Prevailing wages for public works: violations, penalties, and fees	23 N.J.R. 2945(b)	R.1991 d.611	23 N.J.R. 3812(a)
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12:210-1	Apparel industry registration	23 N.J.R. 2951(a)	R.1991 d.607	23 N.J.R. 3816(b)
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12A:31-2.3, 2.7	Loan Guarantee Program for small, minority, and women's businesses: financial statements	23 N.J.R. 2627(a)		
12A:121-1.2, 2	Urban Enterprise Zone program: extension of 50 percent sales tax exemption to qualified municipalities	23 N.J.R. 1893(b)	R.1991 d.591	23 N.J.R. 3761(a)
12A:121-1.2, 2	Urban Enterprise Zone program: public hearing and reopening of comment period regarding extension of 50 percent sales tax exemption to qualified municipalities	23 N.J.R. 2885(a)		

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LAW AND PUBLIC SAFETY—TITLE 13

13:1A	Repeal Legislative Activities Disclosure Act rules (see 19:25-20)	23 N.J.R. 3077(a)		
13:18-11.3, 11.4, 11.5	Access to Division of Motor Vehicles records	23 N.J.R. 2857(a)	R.1991 d.575	23 N.J.R. 3520(a)
13:20-41	Persian Gulf War commemorative license plates	23 N.J.R. 2916(a)	R.1992 d.20	24 N.J.R. 108(a)
13:27-6.2–6.5	Certified landscape architects: site planning services	23 N.J.R. 1516(a)	R.1991 d.550	23 N.J.R. 3337(b)
13:30-8.4	Announcement of practice in special area of dentistry	23 N.J.R. 3429(a)		
13:31-1	Board of Examiners of Electrical Contractors: administration and procedure	23 N.J.R. 2917(a)	R.1991 d.596	23 N.J.R. 3762(a)
13:31-1.4	Exempt electrical work and use of qualified journeyman electrician	23 N.J.R. 979(a)		
13:32-1.8	Licensed master plumber: scope of practice	23 N.J.R. 1062(a)		
13:33-1.20, 1.21, 1.22, 1.23, 1.41	Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians: fees	23 N.J.R. 3631(a)		
13:35-2.5	Medical standards for screening and diagnostic testing offices	23 N.J.R. 2858(a)		
13:35-2.6–2.12, 2.14, 2A	Certified nurse midwife practice	23 N.J.R. 3632(a)		
13:35-3.6	Bioanalytical laboratories: acceptance by director of requests for test of human material	23 N.J.R. 23(a)	R.1991 d.565	23 N.J.R. 3520(b)
13:35-6.4, 6.16, 6.17	Corporate medical practices and Medical Board licensees	23 N.J.R. 161(a)		
13:35-6.4, 6.16, 6.17	Corporate medical practices and Medical Board licensees: public hearing	23 N.J.R. 1063(a)		
13:35-6.7	Practice of medicine: prescribing of amphetamines and sympathomimetic amine drugs	23 N.J.R. 2248(a)	R.1991 d.597	23 N.J.R. 3763(a)
13:35-6A	Medical practice: declaration of death upon basis of neurological criteria	23 N.J.R. 3635(a)		
13:36-7	Board of Mortuary Science: practice regarding persons who died of infectious or contagious disease	23 N.J.R. 1517(a)		
13:36-10	Mortuary science licensees: continuing education	23 N.J.R. 1277(a)		
13:38-1.2, 1.3	Practice of optometry: permissible advertising	23 N.J.R. 2002(a)		
13:39-5.8	Prescriptions and medication orders transmitted by technological devices	23 N.J.R. 2469(a)		
13:40-7.2–7.5	Certified landscape architects: site planning services	23 N.J.R. 1516(a)	R.1991 d.550	23 N.J.R. 3337(b)
13:40A	Board of Real Estate Appraisers rules	23 N.J.R. 2628(a)	R.1991 d.598	23 N.J.R. 3763(b)
13:41-4.2–4.5	Certified landscape architects: site planning services	23 N.J.R. 1516(a)	R.1991 d.550	23 N.J.R. 3337(b)
13:44D-2.4	Advisory Board of Public Movers and Warehousemen: late license renewal fee	23 N.J.R. 3638(a)		
13:44E-1.1	Scope of chiropractic practice	23 N.J.R. 2100(a)		
13:44E-2.3	Chiropractic practice: insurance claim forms	23 N.J.R. 1279(b)		
13:44E-2.6	Chiropractic practice identification	23 N.J.R. 1896(a)		
13:45A-25.2, 25.4	Sellers of health club services: registration fees	23 N.J.R. 3637(a)		
13:45B	Employment and personnel services	23 N.J.R. 2470(a)		
13:45B	Employment and personnel services: extension of comment period	23 N.J.R. 2919(a)		
13:47	Legalized games of chance	23 N.J.R. 3638(b)		
13:47K-5.2	Commodities in package form: request for public input regarding Magnitude of Allowable Variations (MAVs)	23 N.J.R. 3645(a)		
13:54	Regulation of firearms	23 N.J.R. 2250(a)	R.1991 d.564	23 N.J.R. 3521(a)
13:54	Regulation of firearms: extension of comment period	23 N.J.R. 2919(b)		
13:60	Motor carrier safety	23 N.J.R. 3725(a)		
13:70-1.3	Thoroughbred racing: authority of executive director of Racing Commission	23 N.J.R. 3431(a)		
13:70-2.1	Thoroughbred racing: "advance wagers", "delay period", "early bird wagering"	23 N.J.R. 2266(a)	R.1991 d.546	23 N.J.R. 3340(a)
13:70-14A.9	Thoroughbred racing: first-time respiratory bleeders	23 N.J.R. 2919(c)	R.1992 d.19	24 N.J.R. 108(b)
13:70-29.48	Thoroughbred racing: field horses in daily double races	23 N.J.R. 3431(b)		
13:70-29.55	Thoroughbred racing: cash-sell wagering system	23 N.J.R. 2266(b)	R.1991 d.547	23 N.J.R. 3340(b)
13:70-29.57	Thoroughbred racing: pick-seven wager on Breeders' Cup	23 N.J.R. 1769(b)		
13:70-29.59	Thoroughbred racing: cancellation of certain wagers	23 N.J.R. 2267(a)	R.1991 d.542	23 N.J.R. 3340(c)

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13:70-29.60	Thoroughbred racing: expiration of mutuel tickets and vouchers	23 N.J.R. 2267(b)	R.1991 d.543	23 N.J.R. 3341(a)
13:71-1.1	Harness racing: authority of executive director of Racing Commission	23 N.J.R. 3432(a)		
13:71-4.1	Harness racing: "advance wagers", "delay period", "early-bird wagering"	23 N.J.R. 2267(c)	R.1991 d.545	23 N.J.R. 3341(b)
13:71-23.8	Harness racing: first-time respiratory bleeders	23 N.J.R. 2919(d)	R.1992 d.18	24 N.J.R. 109(a)
13:71-27.47	Harness racing: field horses in daily double races	23 N.J.R. 3432(b)		
13:71-27.52	Harness racing: cash-sell wagering system	23 N.J.R. 2268(a)	R.1991 d.540	23 N.J.R. 3341(d)
13:71-27.55	Harness racing: pick-eight wager on Breeders' Crown	23 N.J.R. 1770(a)		
13:71-27.57	Harness racing: cancellation of certain wagers	23 N.J.R. 2268(b)	R.1991 d.541	23 N.J.R. 3342(a)
13:71-27.58	Harness racing: expiration of mutuel tickets and vouchers	23 N.J.R. 2269(a)	R.1991 d.544	23 N.J.R. 3341(c)
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PUBLIC UTILITIES—TITLE 14				
14:0	Open Network Architecture (ONA): preproposal and public hearing regarding Board regulation of enhanced telecommunications services	23 N.J.R. 3239(a)		
14:1	Rules of practice of Board of Public Utilities: waiver of expiration provision of Executive Order No. 66 (1978)	23 N.J.R. 24(b)		
14:1	Rules of practice of Board of Public Utilities	23 N.J.R. 2487(a)		
14:5	Electric service	23 N.J.R. 1519(a)	R.1991 d.583	23 N.J.R. 3652(a)
14:5A	Nuclear generating plant decommissioning: periodic cost review and trust funding reporting	23 N.J.R. 3239(b)		
14:10-6	Alternate operator service: preproposed amendments	23 N.J.R. 676(b)		
14:10-6, 7, 8	Alternate operator service; resale of telecommunications services; customer provided pay telephone service: public hearings on preproposal rules	23 N.J.R. 946(a)		
14:10-7	Resale of telecommunications services: preproposed new rules	23 N.J.R. 679(a)		
14:10-8	Customer provided pay telephone service: preproposed new rules	23 N.J.R. 680(a)		
14:12	Demand side management	23 N.J.R. 1283(a)	R.1991 d.549	23 N.J.R. 3368(a)
14:12-6.1	Release of customer lists and billing information for demand-side management projects	23 N.J.R. 1282(b)		
14:18-7.7	Cable television: telephone system performance	23 N.J.R. 2273(a)	R.1991 d.594	23 N.J.R. 3768(a)
14:38-1.2, 2.1–2.3, 3.1–3.3, 4.1, 5.6, 6.2, 7.1, 7.3, 7.6, 8.1–8.4, 9.1, 9.2	Home Energy Savings Program	23 N.J.R. 1069(b)		
	Most recent update to Title 14: TRANSMITTAL 1991-9 (supplement October 21, 1991)			
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14A:11-2	Reporting of energy information by home heating oil suppliers	23 N.J.R. 2830(b)		
	Most recent update to Title 14A: TRANSMITTAL 1991-4 (supplement April 15, 1991)			
STATE—TITLE 15				
15:2-4	Commercial recording: designation of agent to accept service of process	23 N.J.R. 2483(a)		
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	Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)			
TRANSPORTATION—TITLE 16				
16:25-1.1, 1.7, 2.1, 7A.1, 7A.3, 7A.4, 11.3	Utility accommodation	23 N.J.R. 3739(c)		
16:28-1.38	Speed limit zone along Route 57 in Hackettstown	23 N.J.R. 3128(b)	R.1992 d.7	24 N.J.R. 113(a)
16:28-1.41	Middle Township Elementary School zone along U.S. 9, Cape May County	23 N.J.R. 2831(a)	R.1991 d.585	23 N.J.R. 3770(a)
16:28A-1.6, 1.50, 1.57	Bus stop zones along Route 7 in Nutley, Route 166 in Dover Township, and U.S. 206 in Bordentown	23 N.J.R. 3129(a)	R.1992 d.6	24 N.J.R. 114(a)
16:28A-1.7, 1.20	Restricted stopping and standing along U.S. 9 in Port Republic and Route 29 in Hopewell Township	23 N.J.R. 3269(a)		
16:28A-1.55	Time limit parking along U.S. 202 in Bernardsville	23 N.J.R. 3742(a)		
16:28A-1.106	No stopping or standing zones along Truck U.S. 1 and 9 in Hudson County	23 N.J.R. 3645(b)		

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16:29-1.70, 1.71, 1.72	No passing zones along Route 50 in Atlantic County, Route 41 in Gloucester County, and Route 143 in Camden County	23 N.J.R. 3130(a)	R.1992 d.8	24 N.J.R. 115(a)
16:30-9.10	Prohibited pedestrian use of Barnegat Bay bridges in Dover Township	23 N.J.R. 3131(a)	R.1992 d.9	24 N.J.R. 115(b)
16:32-3.1, 3.6	Operation of 53-foot semitrailers in State	23 N.J.R. 2485(a)	R.1991 d.548	23 N.J.R. 3342(b)
16:41-2.2	State Highway Access Management Code	23 N.J.R. 1525(a)		
16:41-2.2	State Highway Access Management Code: public hearings and correction to proposal	23 N.J.R. 1913(a)		
16:44-1	Classification of contractors and prospective bidders	23 N.J.R. 3270(a)	R.1992 d.29	24 N.J.R. 115(c)
16:47	State Highway Access Management Code	23 N.J.R. 1525(a)		
16:47	State Highway Access Management Code: public hearings and correction to proposal	23 N.J.R. 1913(a)		
16:47-App. B, E, E1, J	State Highway Access Management Code	23 N.J.R. 2831(b)		
16:74	NJ TRANSIT: destructive competition claims procedure for private route bus carriers	23 N.J.R. 1773(a)	R.1991 d.593	23 N.J.R. 3770(b)

Most recent update to Title 16: TRANSMITTAL 1991-10 (supplement October 21, 1991)

TREASURY-GENERAL—TITLE 17

17:1-12.9	County and municipality early retirement incentive program: deadline for filing participation resolutions	23 N.J.R. 2847(a)	R.1991 d.581	23 N.J.R. 3654(a)
17:3-4.1	Teachers' Pension and Annuity Fund: creditable salary	23 N.J.R. 3274(a)		
17:5-4.3	State Police Retirement System: purchases of service credit	23 N.J.R. 1896(b)	R.1992 d.4	24 N.J.R. 109(b)
17:9-4.1, 4.5	State Health Benefits Program: "appointive officer"	23 N.J.R. 2612(b)		
17:14-1.9	Minority and female businesses: subcontracting targets	23 N.J.R. 395(b)		
17:25-1.1, 1.2, 1.3, 1.5, 1.11, 1.12	Collection of debts owed NJHEAA by employees in certain State, county, and municipal jurisdictions	23 N.J.R. 2226(a)		

Most recent update to Title 17: TRANSMITTAL 1991-9 (supplement October 21, 1991)

TREASURY-TAXATION—TITLE 18

18:2-2.7	Abatement of penalty and interest for failure to pay tax or file return	23 N.J.R. 1899(a)	R.1991 d.528	23 N.J.R. 3342(a)
18:3-2.1	Tax rates on alcoholic beverages	23 N.J.R. 3433(a)		
18:7-5.1, 5.10, 14.17	Corporation Business Tax: intercompany and shareholder transactions	23 N.J.R. 1522(a)		
18:7-13.1	Corporation Business Tax: abatements of penalty and interest	23 N.J.R. 3275(a)		
18:12-7.15	Homestead rebate: extension of filing date	23 N.J.R. 1464(a)	R.1991 d.527	23 N.J.R. 3345(a)
18:18A	Petroleum Gross Receipts Tax	22 N.J.R. 3715(a)		
18:24-1.4	Sales tax: manufacturers' coupons	23 N.J.R. 3433(b)		
18:24-2.16	Sales and Use Tax: registration of amusement event promoters	23 N.J.R. 3275(b)		
18:24-9.11	Sales and Use Tax: exempt organizations carrying on trade or business	23 N.J.R. 2005(a)	R.1991 d.577	23 N.J.R. 3654(b)
18:24-16.6, 16.7, 16.9, 17.1-17.4	Vending machine sales	23 N.J.R. 396(a)	R.1991 d.557	23 N.J.R. 3345(b)
18:35-1.14, 1.25	Gross Income Tax: partnerships	23 N.J.R. 950(b)		

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TITLE 19—OTHER AGENCIES

19:3A-1.3	Hackensack Meadowlands Development Commission: petitions for rulemaking	23 N.J.R. 1917(a)	R.1991 d.553	23 N.J.R. 3346(a)
19:4-6.27, 6.29, 6.30	Hackensack Meadowlands Development Commission: District zoning and rule changes	23 N.J.R. 1917(a)	R.1991 d.553	23 N.J.R. 3346(a)
19:16	Labor disputes in public fire and police departments: preproposal regarding compulsory interest arbitration	23 N.J.R. 2486(a)		
19:25-11.12	ELEC: fundraising through use of 900 line telephone service	23 N.J.R. 956(a)		
19:25-20	ELEC: lobbyists and legislative agents	23 N.J.R. 3077(a)		
19:61	Rules of Executive Commission on Ethical Standards	23 N.J.R. 3436(b)		

Most recent update to Title 19: TRANSMITTAL 1991-4 (supplement August 19, 1991)

TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY

19:40-1.2	Twenty-four hour gaming	23 N.J.R. 3243(a)		
19:40-3.1, 3.4, 3.5	Information and filings: administrative filings	_____	_____	23 N.J.R. 3655(a)
19:41-9.3	Administrative suspension of license or registration, or dismissal of application upon determination of unpaid fees or civil penalties	23 N.J.R. 3249(a)		

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19:41-9.6	Slot machine demonstration permit; possession and transportation of slot machines	23 N.J.R. 3729(a)		
19:41-11.1	Vendor registration form	23 N.J.R. 2486(b)	R.1991 d.531	23 N.J.R. 3347(a)
19:42-5.9, 5.10	Underage gaming violations; affirmative defenses	23 N.J.R. 3084(a)	R.1992 d.12	24 N.J.R. 109(c)
19:42-10	Administrative suspension of license or registration, or dismissal of application upon determination of unpaid fees or civil penalties	23 N.J.R. 3249(a)		
19:43-1.2	Determination of casino service industries	23 N.J.R. 1963(a)		
19:44-8.3	Gaming schools: red dog instruction	23 N.J.R. 3731(a)		
19:45-1.1, 1.2, 1.46, 1.47	Complimentary distribution programs	23 N.J.R. 1308(a)		
19:45-1.1, 1.14, 1.15, 1.34	Master coin bank and coin vaults	23 N.J.R. 3085(a)		
19:45-1.1A, 1.15, 1.20, 1.25, 1.27, 1.31, 1.33, 1.34, 1.35, 1.39, 1.40, 1.40A, 1.41, 1.42, 1.43, 1.46A	Twenty-four hour gaming	23 N.J.R. 3243(a)		
19:45-1.11	Casino management information systems department	23 N.J.R. 3434(a)		
19:45-1.11, 1.12	Implementation of red dog	23 N.J.R. 2231(a)	R.1991 d.532	23 N.J.R. 3348(a)
19:45-1.11, 1.12	Implementation of sic bo	23 N.J.R. 2922(a)	R.1991 d.615	23 N.J.R. 3820(b)
19:45-1.12A	Low limit table games: operation and conduct	23 N.J.R. 3250(a)		
19:45-1.25	Casino checks issued to patrons	23 N.J.R. 3087(a)	R.1992 d.13	24 N.J.R. 110(a)
19:45-1.27, 1.27A	Voluntary suspension of patron's credit privileges	23 N.J.R. 3434(b)		
19:45-1.37, 1.39, 1.40A	Progressive slot jackpots and jackpots of merchandise	23 N.J.R. 1306(a)		
19:45-1.38	Movement of slot machines and bill changers	23 N.J.R. 2920(a)		
19:45-1.39	Progressive slot machine submissions	23 N.J.R. 28(a)		
19:45-1.40A, 1.40B	Annuity jackpots	23 N.J.R. 1025(b)	R.1991 d.584	23 N.J.R. 3655(b)
19:45B-1.40B	Annuity jackpots: administrative correction	_____	_____	23 N.J.R. 3819(a)
19:45-1.40B	Annuity jackpot payouts	23 N.J.R. 2920(b)	R.1991 d.614	23 N.J.R. 3820(a)
19:45-1.41	Slot machine hopper fill procedure	23 N.J.R. 2921(a)		
19:46-1.1, 1.6, 1.9, 1.16, 1.18, 1.19, 1.20	Twenty-four hour gaming	23 N.J.R. 3243(a)		
19:46-1.10	Additional wagers in blackjack	23 N.J.R. 3251(a)		
19:46-1.10	Blackjack table layout: betting areas	23 N.J.R. 3732(a)		
19:46-1.13A, 1.15, 1.16, 1.16A, 1.20	Implementation of sic bo	23 N.J.R. 2922(a)	R.1991 d.615	23 N.J.R. 3820(b)
19:46-1.14, 1.17, 1.19	Implementation of red dog	23 N.J.R. 2231(a)	R.1991 d.532	23 N.J.R. 3348(a)
19:46-1.22, 1.23	Slot machine demonstration permit; possession and transportation of slot machines	23 N.J.R. 3729(a)		
19:46-1.26	Progressive slot jackpots and jackpots of merchandise	23 N.J.R. 1306(a)		
19:46-1.27	Density of slot machines: alternatives	23 N.J.R. 192(a)		
19:46-1.27	Slot machine denominations	23 N.J.R. 3252(a)		
19:47-1.3, 1.6, 2.3, 3.2, 4.2, 5.1, 5.6, 7.2	Optional variations in rules of table games	23 N.J.R. 1784(b)	R.1991 d.551	23 N.J.R. 3350(a)
19:47-2.2, 2.17	Additional wagers in blackjack	23 N.J.R. 3251(a)		
19:47-2.3	Payout odds for blackjack	23 N.J.R. 1781(a)	R.1991 d.534	23 N.J.R. 3351(a)
19:47-2.3	Blackjack: collection of losing wagers	23 N.J.R. 3436(a)		
19:47-2.3, 2.7	Payout odds and payment of blackjack	23 N.J.R. 1781(b)		
19:47-2.3, 2.16	Blackjack: five cards totalling 21 rule	23 N.J.R. 28(b)	R.1991 d.533	23 N.J.R. 3355(a)
19:47-2.6	Dealing "hole" card in blackjack	23 N.J.R. 1782(a)	R.1991 d.536	23 N.J.R. 3353(a)
19:47-2.8	Surrender option in blackjack	23 N.J.R. 1783(a)	R.1991 d.535	23 N.J.R. 3354(a)
19:47-2.11	Splitting pairs in blackjack	23 N.J.R. 1783(b)	R.1991 d.537	23 N.J.R. 3354(b)
19:47-3.3, 4.10, 7.3	Vigorish options in baccarat, minibaccarat, and baccarat-chemin de fer	23 N.J.R. 2926(a)	R.1991 d.616	23 N.J.R. 3824(a)
19:47-6, 8.2	Implementation of red dog	23 N.J.R. 2231(a)	R.1991 d.532	23 N.J.R. 3348(a)
19:47-7.7, 7.8	Dealing of hands	23 N.J.R. 2927(a)		
19:47-8.2, 8.3	Rules of the games: notice of changes	23 N.J.R. 2613(a)	R.1991 d.552	23 N.J.R. 3354(c)
19:47-8.2, 9.1–9.6	Implementation of sic bo	23 N.J.R. 2922(a)	R.1991 d.615	23 N.J.R. 3820(b)
19:50	Casino hotel alcoholic beverage control	23 N.J.R. 3087(b)	R.1992 d.14	24 N.J.R. 110(b)
19:52-1.1, 1.2	Casino entertainment	23 N.J.R. 3092(a)	R.1992 d.15	24 N.J.R. 112(a)

Most recent update to Title 19K: TRANSMITTAL 1991-8 (supplement September 16, 1991)