(For long-term care policies providing both nursing home and non-institutional coverage)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most long term care expenses.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(For policies providing nursing home benefits only)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME ME[illegible]CARE BENEFITS

This is not M[illegible]dicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(For policies providing home care benefits only)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about long term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

(For other health insurance policies not specifically identified in the previous statements)

IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Amended by R.1991 d.121, effective March 4, 1992.
See: 22 N.J.R. 771(a), 23 N.J.R. 690(e).
Amended Appendix text throughout in order to update and clarify changes in Medicare and secondary insurance coverage. Reorganized appendix into Exhibits A through C, with Exhibit C adding new text. Deleted information insert, "Information Concerning Changes to the Medicare Program Effective January 1, 1989," because it is obsolete.
Amended by R.1993 d.26, effective January 4, 1993.
See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).
APPENDIX substantially revised.
Amended by R.1996 d.4, effective January 2, 1996.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).
Exhibits A and B, repealed.
Amended by R.1996 d.295, effective July 1, 1996.
See: 28 N.J.R. 1647(a), 28 N.J.R. 3462(a).

SUBCHAPTER 23A. MEDICARE SUPPLEMENT—UNDER 50 COVERAGE

Authority

N.J.S.A. 17:1C–6(e), 17:1–8.1 and P.L.1995, c.229.

Source and Effective Date

R.1996 d.195, effective April 15, 1996.
See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

11:4–23A.1 Purpose and scope

(a) The purpose of this subchapter is to establish a mechanism to provide Plan C coverage of the standardized Medicare supplement plans to persons under 50 years of age residing in this State who are enrolled in Medicare due to disability, or due to end stage renal disease, until they attain the age of 65.

(b) Except when inconsistent with a provision of this subchapter, the provisions of N.J.A.C. 11:4–23 shall apply.

11:4–23A.2 Definitions

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

"Applicant" means an individual who, at the time of application to the Under 50 Plan, has not attained the age of 50 years. In the event that an applicant for Under 50 Plan coverage is disqualified solely because of age, the date of application to the Under 50 Plan shall be deemed to apply to any application for coverage pursuant to N.J.A.C. 11:4–23B.

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

"Contracting carrier" means an insurer selected and appointed to service the Under 50 Plan in accordance with its plan of operation.

"Financially impaired" means an insurer or HMO which, after August 16, 1995, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations, or an insurer or HMO which is under an order of liquidation, rehabilitation or conservation by a court of competent jurisdiction.

"Health benefits plan" means a hospital and medical expense insurance policy, hospital service corporation contract, medical service corporation contract or health service corporation contract delivered or issued for delivery in this State or a health maintenance organization subscriber contract delivered or issued for delivery in this State.

"HealthStart Plus" means the program providing coverage to pregnant women and infants up to one year of age who are in families with incomes between 185 percent and 300 percent of the poverty level, established pursuant to the Health Care Cost Reduction Act, P.L. 1991, c.187, section 25 (N.J.S.A. 26:2H–18.47).

"HMO" means a health maintenance organization authorized in accordance with N.J.S.A. 26:2J–1 et seq.

"Insurer" means an insurance company or hospital, medical or health service corporation authorized to issue health benefits plans in this State.

"Medicaid" means the program administered by the New Jersey Division of Medical Assistance and Health Services Program in the New Jersey Department of Human Services, providing medical assistance to qualified applicants, in accordance with P.L. 1968, c.413 (N.J.S.A. 30:4D–1 et seq.) and amendments thereto.

"Net earned premium" means the premium earned in New Jersey on health benefits plans, less return premiums thereon and dividends paid or credited to policy or contract holders on the health benefits plans. "Net earned premium" shall include the aggregate premiums earned in the insurer's insured group and individual business and HMO business, including premiums from contracts covering Medicaid and HealthStart Plus recipients and premiums from Medicare cost and risk contracts. "Net earned premium" shall not include premiums from any stop loss or excess coverage to the extent that such coverage:

1. Is issued to self-funded arrangements to reimburse only the self-funded arrangements for expenses exceeding per person or aggregate limits, and for which employees or other individuals are not third party beneficiaries under the policy; and

2. The per person limit is no less than $25,000 per year, and additionally, or in the alternative, the aggregate limit is no less than 110 percent of expected claims.

"Net loss of the contracting carrier" means net earned premiums and any investment income thereon less the amount in claims and reasonable administrative expenses of the contracting carrier paid in the preceding calendar year.

"Net loss of the Under 50 Plan" means the net loss of the contracting carrier plus any administrative expenses of the governing board and any other associated administrative expenses.

"Reasonable administrative expenses of the contracting carrier" means actual expenses or the expense allowance, but in no event shall the administrative expenses exceed 25 percent of premium.

11:4–23A.3 Creation of Medicare Supplement—Under 50 Coverage Plan

(a) There is created in the State of New Jersey a plan to provide Medicare Supplement Plan C coverage of the standardized Medicare supplement plans to New Jersey residents under 50 years of age, and until they attain the age of 65, who are enrolled in Medicare due to disability or due to end stage renal disease to be known as the Medicare Supplement—Under 50 Plan ("Under 50 Plan").

(b) The Under 50 Plan shall be administered by a governing board appointed pursuant to this subchapter and a plan of operation adopted by the governing board and approved by the Commissioner.

(c) Any administrative office of the governing board of the Under 50 Plan shall be located within the State of New Jersey and all meetings of the governing board shall take place in New Jersey. The contracting carrier shall at all times maintain an office and records relating to the Under 50 Plan in the State of New Jersey.

(d) Coverage by the Under 50 Plan shall be provided through a contracting carrier appointed pursuant to this subchapter and the approved plan of operation.

(e) Annually, no later than 120 days after December 31st, the governing board of the Under 50 Plan shall submit to the Commissioner a financial report in a form approved by the Commissioner and an operational report of its activities during the preceding calendar year.

11:4–23A.4 Governing board

(a) The Under 50 Plan shall be administered by a governing board composed of eight directors, one of whom shall be the Commissioner or the Commissioner's designee, one of whom shall be the contracting carrier upon its selection and appointment by the governing board, and six of whom shall be appointed by the Commissioner as follows:

1. Two directors shall be insurers writing Medicare Supplement insurance coverage in this State;

2. One director shall be an HMO nominated by the New Jersey Association of Health Maintenance Organizations;

3. One director shall be an insurer nominated by the Health Insurance Association of America; and

4. Two directors shall be members of the public who are knowledgeable about Medicare Supplement coverages, but who are not employed by or otherwise affiliated with insurers, health maintenance organizations, insurance producers, or other entities of the insurance industry.

(b) No insurer or HMO, its affiliates or subsidiaries shall serve in more than one director position on the governing board at the same time.

(c) The Commissioner, or the Commissioner's designated representative, shall sit ex-officio, and shall be a non-voting member of the governing board.

(d) The initial directors appointed to the governing board pursuant to this subchapter shall serve for staggered terms of one or two years, as determined by the Commissioner, or until successors are appointed. Thereafter, all directors of the governing board shall serve for two years or until a successor is appointed.

(e) Each director, other than the two directors who are members of the public, shall designate a primary and an alternate representative to serve on the governing board.

(f) Directors shall serve without compensation but directors who are members of the public may be reimbursed for reasonable expenses as set forth in the plan of operation.

(g) All meetings of the governing board shall be conducted in accordance with this subchapter and the approved plan of operation.

(h) The governing board shall have the power and duty to:

1. Develop and submit to the Commissioner for approval a plan of operation;

2. Establish minimum requirements and performance standards for the contracting carrier, which shall include evidence of prior experience in providing and servicing standardized Medicare supplement insurance policies or contracts in this State;

3. Establish procedures to select an auditor to review the operations of the contracting carrier relating to the Under 50 Plan;

4. Review the auditor's report and implement any recommendations determined to be appropriate;

5. Retain appropriate actuarial, accountant, or other employees, professionals and contractors as necessary to provide technical assistance in the operation of the Under 50 Plan; and

6. Perform such other functions as may be necessary and proper in accordance with this subchapter and the approved plan of operation.

11:4–23A.5 Plan of operation

(a) The plan of operation shall provide for the fair, reasonable and equitable administration of the Under 50 Plan and shall include:

1. The internal organization and proceedings of the governing board;

2. Provisions are permitted which state that, with respect to each insured, coverage is incontestable after it has been in effect during the lifetime of that insured for two years, but only if the following requirements are met:

i. The insurer shall provide written notice to the policyowner at the end of the second policy year requesting that the policyowner notify the insurer of the death of any insured. The notice shall additionally state that failure to provide notice of death will not preclude a contest, and could result in a contest even if premium payments continue to be made. A sample copy of the notice shall be submitted for Department review;

ii. The contestability provision in the form shall describe the mailing of the notice in (b)2i above and shall state the adverse implications for the policyowner's failure to provide the insurer with timely notice of death;

iii. A copy of the insurer's notice and any policyowner reply shall remain on file with the insurer; and

iv. Any action of contest shall commence promptly upon notice of death.

(c) Survivorship forms shall satisfy the following requirements on suicide:

1. The insurer shall be permitted to rescind a contract as a result of suicide when both insureds or the surviving insured commit suicide during the first two years;

2. Except as provided in paragraph (c)3 below, the insurer shall reform and reissue the contract as of the original effective date as a single life contract on the surviving insured where only the first insured to die commits suicide during the first two years.

i. The insurer shall provide the single-life coverage automatically without evidence of insurability, which shall be substantially the same as the coverage provided under the original survivorship policy.

ii. Any suicide and contestability provisions of the reformed and reissued contract shall be effective as of the effective date of the original survivorship form;

3. As an alternative to the reformed and reissued contract, the insurer shall be permitted to continue the original policy as a survivorship contract.

i. The form's suicide provision shall include a description of either the reformed and reissued contract at (c)2 above, or the survivorship contract at (c)3 above;

4. Insurers shall not be permitted to avoid the provision of single life coverage on the life of the survivor even if such surviving insured is uninsurable at the time of the death, was uninsurable at the time the original policy was issued, or is in a different premium class at the time of the death than at the time the original policy was issued; and

5. Any time limits with respect to the process of changing coverage from joint to single life coverage shall satisfy the following standards:

i. The suicide provision shall include the requirement that proof of first death shall be provided to the insurer. In the case of first death by suicide, such proof shall be provided within 90 days of the death;

ii. The provision shall indicate that the insurer shall provide information no later than 30 days after receiving notification of the death regarding any payments required for the single life coverage (for example, the new premium amount) which may be required;

iii. The provision shall allow the owner a 60–day period after receiving notification from the insurer to pay the amount(s) required; and

iv. The provision shall describe the death benefit payable in the event the survivor dies prior to expiration of the 60–day period allowed for payment without having made the payment. Such death benefit shall be based on the full face amount of the original survivorship policy net of the premium and any other required amount remaining due and payable.

(d) Insurer contestability and suicide practices for riders used with survivorship contracts shall be consistent with those for the base policy.

(e) The form shall include a provision directing the owner to submit to the insurer proof of death upon the first death.

11:4–41.14 Standards for re-entry or requalification features

(a) The following standards shall apply to coverage which provides a re-entry or requalification feature:

1. The Department shall require a certification that the insurer will not attempt to defeat the requalification provision by markedly altering its underwriting standards between the time of issue and the time of requalification. In this context, a change in the underwriting standards refers to the level of expected mortality needed to requalify, and not to the tests or information used to arrive at this estimate of expected mortality.

2. The percentage of insureds requalifying shall not be used as a basis for changing any indeterminate premium.

3. The current premiums for insureds not requalifying shall be based on realistic assumptions which reflect the anti-select nature of this risk pool.

4. The provision describing requalification shall state whether such requalification is contestable or subject to a new suicide period.

5. If requalification involves a reduction in premium on the same policy to a level below the premium which would have been charged without underwriting, then only the difference in the policy face amount which is attributable to the difference in premium shall be contestable for up to two years following the date of re-entry, if any right to contest is reserved.

6. If requalification requires issuance of a new policy at current rates, the entire contract may be contestable for up to two years following the date of requalification, if so stated. Such a transaction shall be a replacement and the insurer shall be required to satisfy the requirements of N.J.A.C. 11:4–2. Insurers shall include specimen copies of disclosure forms with their forms submission to the Department.

11:4–41.15 Standards for custom design products

(a) The Department shall permit the use of a single policy form to provide more than one product where there are distinguishable alternative plans. The plans are distinguishable if the schedule pages and any related tables of values have unique identifying form numbers, and a separate actuarial memorandum exists for each plan.

(b) The use of single policy forms to provide more than one product shall be permitted under the following circumstances:

1. Whole life coverage where the only difference is the length of the premium paying period.

2. Decreasing term plans where the only difference is the length of the term period. The Department shall permit different amortization schedules to be used with each term period.

3. Level term plans where the only difference is the length of the term.

(c) The use of single policy forms to provide more than one product shall not be permitted under the following circumstances:

1. A policy form may not be issued as both a single premium plan and a multiple premium plan.

2. A policy form may not be issued with more than one mortality table. Separate policy forms are required for the 1980 CSO Table, 1980 CSO Smoker/Nonsmoker, and each gender blended version of these tables.

3. A policy form may not be issued with more than one scale of guaranteed interest rate(s) used in determining cash values.

4. A policy form may not be issued both for plans which are exempt from providing cash values under the Standard Nonforfeiture Law (N.J.S.A. 17B:25–19) and for plans which are required to provide cash values.

5. A policy form providing term coverage may not be issued for separate plans providing a level death benefit or a non-level death benefit.

6. A policy form may not be issued as both a single life plan and a multiple life plan.

7. A policy form may not be issued as both a first-to-die and a survivorship plan.

8. A policy form may not be issued both with and without a re-entry or requalification provision.

9. A policy form may not be issued both with and without a minimum premium period, or for minimum premium periods of different durations.

10. A policy form may not be issued both with and without a surrender charge.

11. A policy form may not be issued by an agent in the field and by the home office.

12. A policy form may not be issued both as a renewable and nonrenewable term plan.

11:4–41.16 Effect on previously filed forms

Forms which have been filed by the Commissioner pursuant to N.J.S.A. 17B:25–18 containing provisions not in compliance with these rules shall be deemed withdrawn as of six months following the effective date of these rules.

SUBCHAPTER 42. GROUP LIFE, GROUP HEALTH AND BLANKET INSURANCE: GENERAL STANDARDS FOR CONTRACT PROVISIONS

Authority

N.J.S.A. 17:1–8.1, 17:1C–6 and P.L.1995, c.73.

Source and Effective Date

R.1996 d.196, effective April 15, 1996.
See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

11:4–42.1 Purpose and scope

(a) This subchapter sets forth standards for provisions contained in group life, group health and blanket insurance contract, policy and certificate forms to assure that the provisions are not unjust, unfair, inequitable, misleading, confusing or unreasonably restrictive and that the coverage provided is not so limited as to provide no substantial economic value.