NEW JERSEY REGISTER

THE JOURNAL OF STATE AGENCY RULEMAKING

VOLUME 25 NUMBER 22

November 15, 1993 Indexed 25 N.J.R. 4981-5382

(Includes adopted rules filed through October 21, 1993)

EDUCATION, DEPARTMENT OF
DIV. LIBRARY, ARCHIVES & HISTORY
CN 520
TRENTON NJ 08625 INTER-OFFICE

MOST RECENT UPDATE TO NEW JERSEY ADMINISTRATIVE CODE: SEPTEMBER 20, 1993
See the Register Index for Subsequent Rulemaking Activity.

NEXT UPDATE: SUPPLEMENT OCTOBER 18, 1993

RULEMAKING IN THIS ISSUE

EXECUTIVE ORDERS

OFFICE OF THE GOVERNOR
Executive Order No. 106(1993): New Jersey Independent Living Council ..... 4983(a)
Executive Order No. 107(1993): Designation of Commissioner of Labor to Act on Behalf of Governor concerning Job Training Partnership Act Programs ..... 4984(a)
Executive Order No. 108(1993): Governor's Commission on Women's Health ..... 4984(b)

RULE PROPOSALS

Interested persons comment deadline 4982

AGRICULTURE
Animal health: biologics for diagnostic or therapeutic purposes ..... 4985(a)
COMMUNITY AFFAIRS
New home warranties and builder registration: claims procedure ..... 4986(a)
ENVIRONMENTAL PROTECTION AND ENERGY
Sanitary Landfill Facility Closure and Contingency Fund: processing of damage claims ..... 5116(a)
Air quality management: enhanced Inspection and Maintenance program ..... 5130(a)
HUMAN SERVICES
Manual of Requirements for Child Care Centers ..... 4987(a)
INSURANCE
Small Employer Health Benefits Program ..... 5017(a)
Real Estate Commission: extension of comment periods on various licensure and prelicensure proposals ..... 5099(a)
LABOR
Division of Vocational Rehabilitation Services ..... 5130(b)
LAW AND PUBLIC SAFETY
Board of Medical Examiners: physician assistants ..... 5099(b)
Weights and measures ..... 5102(a)
State Medical Examiner: standards for procedures and investigations ..... 5104(a)
Thoroughbred racing: conflicts of interest involving veterinary practitioner and spouse ..... 5107(a)
Thoroughbred racing: trainer fees ..... 5107(b)
Harness racing: conflicts of interest involving veterinary practitioner and spouse ..... 5108(a)
Harness racing: Daily Triple ..... 5109(a)
Casino simulcasting of horse races ..... 5110(a)
PUBLIC UTILITIES
Filing of Demand Side Management Resource Plans ..... 5111(a)
TRANSPORTATION
Time limit parking zone along Route 28 in Somerville .. 5111(b)
No stopping or standing zones along Route 71 in Spring Lake Heights ..... 5112(a)
TREASURY-GENERAL
Public Employees' Retirement System: replacement of member-trustee who declines to serve ..... 5113(a)
CASINO CONTROL COMMISSION
Approval of listings of uncollectible checks ..... 5114(a)
Casino employee reporting and recordkeeping requirements; experiential hours ..... 5114(b)
Hearings: multiple party representation ..... 5115(a)

RULE ADOPTIONS

BANKING
Payment of stock options to directors, officers and employees of State depositories ..... 5145(a)
PERSONNEL
Residence requirements: administrative correction ..... 5145(b)

(Continued on Next Page)

INTERESTED PERSONS

Interested persons may submit comments, information or arguments concerning any of the rule proposals in this issue until **December 15, 1993.** Submissions and any inquiries about submissions should be addressed to the agency officer specified for a particular proposal.

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

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

RULEMAKING IN THIS ISSUE—Continued

COMMUNITY AFFAIRS
- Uniform Construction Code: minor work; ordinary repairs ... 5145(c)
- Uniform Construction Code: "Notice of Elevator Device Sealed Out of Operation" ... 5146(a)

ENVIRONMENTAL PROTECTION AND ENERGY
- Coastal zone management: Outer Continental Shelf oil and gas exploration and development ... 5146(b)
- Medical diagnostic x-ray installations: administrative correction ... 5148(a)

HEALTH
- Pilot low-cost spaying and neutering clinic surgery fees ... 5148(b)
- Hospital financing ... 5149(a)
- Hospital reimbursement: charity care audit functions ... 5154(a)
- Hospital Policy Manual: capital cap and review process ... 5161(a)
- Invalid coach and ambulance services: licensure; street EMS ... 5163(a)
- Operation of clinical laboratories ... 5164(a)
- Physician reporting of occupational and environmental diseases and injuries ... 5164(b)

HUMAN SERVICES
- Contract administration ... 5165(a)
- Home Care Services Manual ... 5167(a)
- Lifeline Programs ... 5167(b)
- Deeming income of parents or guardians of adolescent parent ... 5168(a)
- DYFS case management: in-person visits with clients and substitute care providers ... 5168(b)

CORRECTIONS
- Sanctions for prohibited acts committed by inmates ... 5169(a)
- Blood donation by inmates: autologous donations ... 5170(a)

INSURANCE
- Insurance holding company systems ... 5170(b)
- Examination of insurers ... 5180(a)
- Determination of insurers in a hazardous financial condition ... 5182(a)
- Credit for reinsurance ... 5184(a)
- Surplus lines: allocation of premium tax and surcharge ... 5194(a)
- Risk retention groups and purchasing groups ... 5197(a)
- Producer-controlled insurers ... 5202(a)
- Increase in property and casualty capital and surplus requirements ... 5204(a)
- Increase in capital and surplus requirements for life and health insurers ... 5208(a)
- Life, health and annuity reinsurance agreements ... 5212(a)
- Personal Automobile Insurance Plan ... 5215(a)
- Reimbursement of excess medical expense benefits paid by automobile insurers ... 5219(a)
- Real Estate Commission rules ... 5229(a)
- Statement of liability for fraud on claim forms: administrative correction ... 5229(b)
- Managing general agents ... 5229(c)
- Reinsurance intermediaries ... 5234(a)
- Individual Health Coverage Program: temporary plan of operation ... 5244(a)
- Small Employer Health Benefits Program ... 5253(a)
- Small Employer Health Benefits Program: declaration and approval of reinsuring or risk-assuming carrier status ... 5347(a)

LABOR
- Unemployment Compensation and Temporary Disability: 1994 maximum benefit rates, taxable wage base, government entity contribution rate, base week, and alternative earnings test ... 5351(a)
- Offset of unemployment benefits by retirement and pension income ... 5352(a)
- Workers' Compensation: 1994 maximum benefit rate ... 5352(b)

LAW AND PUBLIC SAFETY
- Board of Accountancy: biennial renewal fee for inactive or retired licensees ... 5352(c)
- Board of Dentistry: fee schedules ... 5352(d)
- Safe and Secure Communities Program ... 5353(a)

TRANSPORTATION
- Speed limit zones along U.S. 40, U.S. 40 and 322, and Route 87 in Atlantic County ... 5356(a)
- Parking restrictions along Route 28 in Bound Brook ... 5356(b)
- Restricted parking along Route 77 in Bridgeton ... 5357(a)
- Time limit parking in Bridgeton ... 5358(a)
- Weight limit on Edison Bridge along U.S. 9 over Raritan River ... 5358(b)
- Midblock crosswalk on Route 71 in Belmar ... 5358(a)

CASINO CONTROL COMMISSION
- Vendor Registration Form: Junket Enterprise Registration Form ... 5359(b)
- Reapplication for employee licensure or registration after denial or revocation; motions for reconsideration or relief ... 5360(a)
- Ineligibility of successor business for provisional certification as a women or minority business enterprise ... 5361(a)

(Continued on Page 5382)

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.

The New Jersey Register (ISSN 0300-6069) is published the first and third Mondays (Tuesday, if Monday is a holiday) of each month by OAL Publications of the Office of Administrative Law, CN 301, Trenton, New Jersey 08625. Telephone: (609) 588-6606. Subscriptions, payable in advance, are one year, $125 ($215 by First Class Mail); back issues when available, $15 each. Make checks payable to OAL Publications.

POSTMASTER: Send address changes to New Jersey Register, CN 301, Trenton, New Jersey 08625. Second Class Postage paid in South Plainfield, New Jersey.

Copyright 1993 New Jersey Office of Administrative Law

EXECUTIVE ORDERS

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 106(1993)
New Jersey Independent Living Council

Issued: October 15, 1993.
Effective: October 15, 1993.
Expiration: Indefinite.

WHEREAS, pursuant to the Rehabilitation Act of 1973, as amended by the Rehabilitation Amendments of 1986 (hereinafter referred to as the "Amendments of 1986"), enacted on October 21, 1986, and known as P.L. 102-569, the State of New Jersey was mandated to establish the New Jersey Independent Living Advisory Council in order to provide the necessary guidance for the development of a State plan to expand independent living services for persons with disabilities Statewide; and

WHEREAS, pursuant to the Rehabilitation Act of 1973, as amended by the Rehabilitation Amendments of 1992 (hereinafter referred to as the "Amendments of 1992"), and known as P.L. 102-569, the State of New Jersey is mandated to redenominate the New Jersey Independent Living Advisory Council to the New Jersey Independent Living Council and to ensure that the redenominated Council shall not be established as an entity within another State agency; and

WHEREAS, pursuant to the Rehabilitation Act of 1973 as amended by the Amendments of 1992, in order to be eligible to receive Federal financial assistance under Title VII, Section 704(a) of P.L. 102-569, the State of New Jersey shall submit to the Commissioner of the Rehabilitation Services Administration, U.S. Department of Education, and obtain approval of, a State plan containing such provisions as the Commisisoner may require, including, at a minimum, a plan that ensures the existence of appropriate planning, financial support and coordination, and other assistance to appropriately address, on a Statewide and comprehensive basis, needs in the State for (a) the provision of State independent living services, (b) the development and support of a Statewide network of centers for independent living, and (c) working relationships between programs providing independent living services and independent living centers, the vocational rehabilitation program established under Title I, Section 101 of P.L. 102-569, and other programs providing services for individuals with disabilities; and

WHEREAS, with its revised name, membership, charge and responsibilities, the New Jersey Independent Living Council should promote a philosophy of independent living, including a philosophy of consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy, in order to maximize the leadership, empowerment, independence, and productivity of individuals with disabilities into the main stream of American society;

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

1. The New Jersey Independent Living Advisory Council is hereby redenominated the New Jersey Independent Living Council (hereinafter referred to as "the Council"). The Council shall be established as a separate entity in, but not of, the New Jersey Department of Labor.

2. The Council shall:

(a) jointly develop and submit (in conjunction with the designated State agencies) the State plan required in Title VII, Part A, Section 704 of P.L. 102-569;

(b) monitor, review, and evaluate the implementation of the State plan;

(c) coordinate activities with the State Rehabilitation Advisory Council established under Title I, Part A, Section 101(a)(3c) and Section 105 of P.L. 102-569, that address the needs of specific disability populations and issues under other Federal law;

(d) ensure that all regularly scheduled meetings of the Council are open to the public and that sufficient advance notice is provided;

(e) submit to the Commissioner of the Rehabilitation Services Administration, U.S. Department of Education such periodic reports as the Commissioner may request, and keep such records, and afford such access to such records, as the Commissioner finds necessary to verify such reports; and

(f) carry out all other duties set forth in Title VII, Section 704 of P.L. 102-569

3. The Council shall consist of no more than 17 voting members appointed by the Governor. The composition of the Council shall reflect a majority of qualified persons with disabilities representing the interest of New Jersey's cross-disability population. The majority of the members appointed to the Council may not be employed by any State agency or center for independent living.

(a) A representative from the Division of Vocational Rehabilitation Services in the Department of Labor, and a representative from the New Jersey Commission for the Blind and Visually Impaired in the Department of Human Services (hereinafter referred to as the "designated State units") shall continue to serve as *ex officio*, nonvoting members on the Council.

(b) The Commissioners of the State departments of Human Services, Labor, Education, and the Public Advocate and/or their designees from the Division of Developmental Disabilities in the Department of Human Services, the Division of Mental Health and Hospitals in the Department of Human Services, the Division of the Deaf and Hard of Hearing in the Department of Human Services, the Division of Special Education in the Department of Education, and the Division of Advocacy for the Developmentally Disabled in the Department of the Public Advocate, shall also serve as *ex officio*, nonvoting members on the Council.

(c) Three directors of centers for independent living (one each from the northern, central and southern regions of the State) shall be selected by the members of the New Jersey Directors Association of Centers for Independent Living to serve on the Council.

(d) The Council shall also consist of:

(1) at least one parent or guardian of an individual with a disability; and

(2) one representative of the private sector business community;

(e) The Council may also be comprised of:

(1) other representatives from centers for independent living;

(2) advocates of and for individuals with disabilities;

(3) representatives from organizations that provide services for individuals with disabilities; and

(4) other appropriate individuals.

(f) Council members shall serve for terms of three (3) years, except for those first appointed, five shall serve for a term of one (1) year, five shall serve for a term of two (2) years, and the remainder shall serve for a term of three (3) years. Council vacancies from among the members shall be filled by appointment by the Governor for the remainder of the unexpired term. No member of the Council can serve more than two (2) consecutive full terms. Any vacancy occurring in the membership of the Council is to be filled in the same manner as an original appointment and the vacancy is not to affect the power of the remaining members to execute the duties of the Council. The Council shall designate a member of the Council to serve as the Chairperson.

4. The Council shall further organize itself and set its own schedule for meetings as it deems necessary to complete its work.

5. The Council is authorized to hold such hearings and forums as the Council may determine to be necessary to carry out the duties of the Council.

6. In performing its work, the Council shall work with other existing bodies in the State designed to plan, coordinate and deliver independent living services to persons with disabilities and their families at the State, county and local levels. The Council may draw upon the assistance of any department, organization or agency of the State which may be made available to it for these purposes.

7. The Council may use such resources to reimburse members of the Council for reasonable and necessary expenses of attending Council meetings and performing Council duties, and to pay compensation to a member of the Council, if such member is not employed or must forfeit wages from other employment, for each day the member is engaged in performing Council duties.

8. Pursuant to Title VII, Section 705(6)(e3) of P.L. 102-569, while assisting the Council in carrying out its duties, staff and other personnel shall not be assigned duties by the designated State agencies or any other agency or office of the State, that would create a conflict of interest.

9. This Order shall take effect immediately.

(a)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 107(1993)
Designation of Commissioner of Labor to Act on Behalf of the Governor Concerning Job Training Partnership Act Programs

Issued: October 21, 1993.
Effective: October 21, 1993.
Expiration: Indefinite.

WHEREAS, New Jersey's economic vitality and the standard of living of its residents depend upon a highly skilled work force and globally competitive work places; and

WHEREAS, the State's economic development strategy relies upon increasing the skills of our work force; and

WHEREAS, the State of New Jersey has embarked on a strategic restructuring of its work force education and training as part of this economic development strategy; and

WHEREAS, the New Jersey Department of Labor and the State Employment and Training Commission have key roles to play in the development of New Jersey's work force readiness system; and

WHEREAS, the Federal "Job Training Partnership Act" (Pub.L. 97-300, 29 U.S.C. §1532, hereinafter referred to as the JTPA) establishes a job training program that is currently a component of New Jersey's work force readiness system; and

WHEREAS, N.J.S.A. 34:15C-1 et seq. creates in the Executive Branch and in, but not of, the Department of Labor, a State Employment and Training Commission (hereinafter referred to as the SETC) to design and help implement a unified work force readiness system for New Jersey, independent of any supervision or control by the department or any other board or officer thereof; and

WHEREAS, the duties of the State Job Training Coordinating Council pursuant to Section 122 of Title I of the JTPA (29 U.S.C. 1532) and Title III of that Act (29 U.S.C. 1651 et seq.) are assigned to the SETC by N.J.S.A. 34:15C-6.f.; and

WHEREAS, funding for the State Job Training Coordinating Council is authorized by Section 202(b)(4) of the JTPA (29 U.S.C. 1602); and

WHEREAS, the execution of the Governor's responsibility under Federal employment laws has historically been defined by Executive Order, beginning with Executive Order No. 5 (Byrne 1974) through all subsequent gubernatorial administrations, to the present;

NOW THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the statutes of the State of New Jersey, do hereby ORDER and DIRECT:

1. The Commissioner of Labor (hereinafter referred to as the Commissioner), is designated to act on behalf of the Governor in the planning, administration, coordination and oversight of programs under the JTPA and, to the extent not inconsistent with the JTPA or State law, shall have sole authority to apply for Federal funds under the JTPA.

2. The Commissioner shall assure that the State is in compliance with the provisions of the JTPA and shall: provide for corrective actions when necessary; exercise the authority of the Governor in resolving disputes; establish planning and performance requirements; determine procedures for awarding incentive funds; and carry out such other responsibilities as specified or implied under the JTPA and its subsequent amendments.

3. The Chairman of the SETC is authorized to determine the budget necessary to carry out the SETC's responsibilities in performing the functions of the State Job Training Coordinating Council under the JTPA. The annual expenditure of an amount not to exceed 20 percent (20%) of the State's five percent (5%) administrative resources available to the Governor under the JTPA is hereby authorized.

4. Executive Order No. 22(1982), 81(1984), 113(1985), 119(1985) and 188(1988) issued by Governor Kean are hereby rescinded.

5. This Order shall take effect immediately.

(b)

OFFICE OF THE GOVERNOR
Governor Jim Florio
Executive Order No. 108(1993)
Governor's Commission on Women's Health

Issued: October 20, 1993.
Effective: October 20, 1993.
Expiration: Indefinite.

WHEREAS, the health of New Jersey women is at risk for conditions that could be detected by routine preventive care services; and

WHEREAS, the cost of these services is a major barrier to adequate care; and

WHEREAS, a large percentage of women have never had any of the basic preventive health care services, including Pap smears, clinical breast examinations, or complete physical examinations, which if undertaken would promote their long-term health; and

WHEREAS, poor, less educated, and minority women are more likely to be uninsured and, thus, not receive necessary medical care; and

WHEREAS, the level of collaboration between New Jersey health care providers, community and corporate leaders, and consumers, as evidenced by the first New Jersey Women's Health Summit held on September 10, 1993, attests to the degree of concern that exists for women's health issues in New Jersey; and

WHEREAS, as we enter an era of health care reform at the State and Federal level, public and private efforts that assure universal health insurance coverage for comprehensive benefits, including preventive services, are essential to removing financial barriers to quality health care for all women;

NOW, THEREFORE, I, JAMES J. FLORIO, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of this State, do hereby ORDER and DIRECT:

1. There is hereby established a Governor's Commission on Women's Health.

2. The Commission shall, within 12 months from the date of this Executive Order:

a. review and assess the system of delivery of health care services to women in New Jersey, and the costs of these services, in order to identify the needs of women and recommend ways to reduce costs and improve the quality and efficiency of these services;

b. prepare and submit a report to the Governor on the status of health care services for women in New Jersey, and make recommendations for policies and programs that will enhance the health and well-being of New Jersey's women, including recommended legislation or regulations.

3. The Commission shall consist of no more than 22 members appointed by the Governor. The Commission shall include the Commissioners of the following State departments: Community Affairs, Education, Health, Human Services, Insurance, Labor, and Law and Public Safety, or their designees. The remaining members shall be appointed by the Governor and shall include representatives of the medical, nursing, legal, education, social services and health care service agency communities.

4. The Commission members will serve without remuneration.

5. The Commissioner of Health will convene the Commission and the Department of Health shall provide the Commission with staff assistance.

6. The Governor shall designate the chairperson and Vice Chairperson of the Commission from among the members of the Commission.

7. The Commission shall further organize itself and set its own schedule for meetings as it deems necessary to complete its work.

8. This Order shall take effect immediately.

RULE PROPOSALS

AGRICULTURE

(a)

DIVISION OF ANIMAL HEALTH

Biological Products for Diagnostic or Therapeutic Purposes

Proposed New Rules: N.J.A.C. 2:6

Authorized By: State Board of Agriculture and Arthur R. Brown, Jr., Secretary, Department of Agriculture.
Authority: N.J.S.A. 4:5-107 et seq.
Proposal Number: PRN 1993-625.

Submit written comments by December 15, 1993 to:
Ernest W. Zirkle, DVM, Director
Division of Animal Health
New Jersey Department of Agriculture
CN 330
Trenton, New Jersey 08625
Telephone (609) 292-3965

The agency proposal follows:

Summary

N.J.A.C. 2:6, Biological Products for Diagnostic or Therapeutic Purposes, expired September 3, 1990 pursuant to the requirements and criteria of Executive Order No. 66(1978). The Department proposes to adopt these new rules in an effort to regulate the sale and use of veterinary vaccines in New Jersey.

These rules do not apply to drugs or chemicals, including antibiotic preparations.

Biologics are complex products with variable applications and effects that have the potential for misuse. The probable results of their misuse can maintain or spread disease, complicate the diagnostic process and fail to provide effective disease protection.

In December 1985, the Congress of the United States amended the Federal Virus, Serum, and Toxins Act of 1913 to include Federal control of intrastate and export sales. Following that, Executive Order 12612 of October 26, 1987 stated in its expression of Fundamental Federalism Principles (Sect. e) that "States uniquely possess the constitutional authority, the resources, and the competence to discern the sentiments of the people and to govern accordingly." Furthermore, (Sect. i) stated that "In the absence of clear constitutional or statutory authority, the presumption of sovereignty should rest with the individual states. Uncertainties regarding legitimate authority of the national government should be resolved against regulation at the national level." Therefore, these rules further clarify the relationship of the State statutes to Federal law and regulations.

These proposed new rules exempt individual registration of most Federally licensed manufacturers or products, and limit the use or retail distribution of all biologics, except poultry, to a veterinarian.

With the exception of dairy farmers and some breeding equine farms, the largest group of livestock owners in New Jersey are niche farmers, such as 4-H and FFA members and land owners with occupations which allow for part time livestock farming. The number of owners within these groups remains rather stable; however, individual ownership frequently changes. Consequently, there is a constant potential for new owners who are unfamiliar with the proper health care and management of the livestock they own. These rules assure, to the extent possible, that these owners receive professional guidance prior to administering biologics with the potential to be harmful to livestock, to be ineffective or to be a waste of time and money.

It should be pointed out that the New Jersey's Veterinary Practice Act includes a strong client-patient relationship clause which requires a veterinarian to have first hand knowledge of the owner's operation before prescribing any medication. However, the New Jersey State Board of Veterinary Medical Examiners has ruled that upon the request of an animal owner a veterinarian must write a prescription. This ruling assures that animal owners can purchase biologics from any authorized source.

The proposed rules do not interfere with the normal distribution channels or labeling procedures of the manufacturer. They do, however, require that retail outlets, other than veterinarians, must accept a prescription from the livestock owner as a condition of sale.

Social Impact

The proposed new rules affect veterinarians, livestock owners and poultrymen by protecting these individuals from the ineffective use of vaccines, serums, antigens and diagnostic agents to determine, prevent and treat animal disease. The risks of not promulgating these rules also include the misuse of these biologics, which could result in the maintenance and spread of infection in livestock, improper handling of the biologic, misdiagnosis of disease entities and mistreatment by laymen. In addition, the rules will protect human health by restricting exposure to disease causing organisms.

Economic Impact

Diagnosis, prevention and treatment of animal diseases, to include the proper use of veterinary biologics, prevents the illness and death of horses, livestock and poultry, and as a consequence increases the economic return of animal agriculture products to farmers. Healthy animals also allow New Jersey farmers the opportunity to compete more effectively in the national and international marketplace for the distribution and sale of animal agriculture products.

A minor degree of economic loss may occur within the animal feedstuff and the pet-animal industry by restricting the sale of biologics. Also, farmers may incur additional expenses related to the need for the professional services of a veterinarian in the treatment of livestock. However, such expenditures should help to prevent the unnecessary illness and loss of livestock and the associated economic loss to farmers as well as unnecessary expenditures on inappropriate and ineffective biologics by laymen. The promulgation of these rules will help insure that biologics are applied in a uniform and safe manner in order to effectively control animal disease which could affect the public welfare.

Regulatory Flexibility Analysis

The restriction of the distribution or use of biologics to veterinarians will have a minimum impact upon the farmers in this State. Most, if not all farmers, are considered small businesses as defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. There are no reporting or recordkeeping requirements created by these rules, however, there are compliance requirements which mandate that biologics be administered or prescribed by a veterinarian. The rules permit non-professional individuals to acquire and use biologic products, if, in the veterinarian's professional opinion, the product is appropriate for that herd under the specific farm setting and practices and the individual is properly trained. Because these rules are concerned with the control of disease and the public welfare, no lessening of or exemption from these requirements is provided.

Full text of the proposed new rules follows:

CHAPTER 6
BIOLOGICAL PRODUCTS FOR DIAGNOSTIC OR THERAPEUTIC PURPOSES

SUBCHAPTER 1. BIOLOGICAL LICENSING

2:6-1.1 Definitions

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

"Accredited veterinarian" means any licensed Doctor of Veterinary Medicine who has fulfilled the requirements for Federal and State accreditation, pursuant to 9 C.F.R. §160.1 et seq. in the State of New Jersey.

"Biological product" or "biologic," "biological" and "biological drug" mean any product utilizing virus (whether active or inactive) or any molecular part thereof, bacteria or any genetic equivalent thereof, or toxin as its basic component, or any product derived from the serum of any other animal, in the diagnosis (diagnostic biologic) or prevention (prophylactic biologic) or animal disease. This includes

any and all products covered by the Animal Virus, Serum, and Toxin Act, 21 U.S.D.A. §§151 et seq., and the regulations issued pursuant thereto, 9 C.F.R. §§101.1 et seq.

"Diagnostic biologic" means a preparation of bacterial, viral or parasitic agents, products, factions, serums, or fractions of serums utilized to determine experience with a disease causing agent.

"Director" means the Director, Division of Animal Health, New Jersey Department of Agriculture.

"Distribution" means the preparation, sale, barter, exchange, or giving away of any regulated product.

"Domestic animal" means any and all animals other than humans.

"Licensed veterinarian" means a Doctor of Veterinary Medicine licensed by the Board of Veterinary Medical Examiners, pursuant to N.J.S.A. 45:16-1 et seq., and the rules issued pursuant thereto, N.J.A.C. 13:44, to practice veterinary medicine, surgery, and dentistry in the State of New Jersey.

"Person" means any individual, corporation, institution or partnership.

"Prophylactic biologic" means any and all vaccines or toxoids used to initiate immunity against disease in domestic animals.

2:6-1.2 Distribution of biologics

(a) Unless otherwise stated, all United States Department of Agriculture (U.S.D.A.) licensed biologics may be distributed and used according to the terms of this chapter.

(b) Nothing in this rule shall prevent individual owners from securing biologics from any USDA authorized source, by prescription, for use on their own animals.

2:6-1.3 Use of biologic products, diagnostic biologics and prophylactic biologics

(a) Only USDA licensed and New Jersey permitted biologic products may be used in New Jersey in accordance with N.J.A.C. 2:6-1.2.

(b) All biologic products, including diagnostic biologics, shall be administered only by or on the order of a licensed veterinarian, except:

1. Prophylactic biologics used to immunize poultry;
2. Brucella Abortus and contagious ecthyma vaccines shall be administered only by accredited veterinarians; and
3. Diagnostic biologics for the following diseases are limited to use by the New Jersey Department of Agriculture, Division of Animal Health only, unless specific written permission is granted by the Director, for in vitro diagnosis of:
   i. Equine Infectious Anemia;
   ii. Brucellosis; and
   iii. Paratuberculosis (Johne's Disease).

(c) Exceptions to (b)3 above may be granted by the Director to other government agencies who may be cooperating with the New Jersey Department of Agriculture, or where in the opinion of the Director, there is an emergent situation requiring immediate action.

2:6-1.4 Revocation of license or permission to distribute or use

(a) A license or permission to distribute or use any biologic product shall be revoked by the Director when there has been a violation of State or Federal laws or regulations, or where the public health, welfare or safety shall warrant such revocation, subject to notice and opportunity to be heard.

(b) Any hearing to be conducted under this section shall be so conducted pursuant to N.J.A.C. 2:1-3.4 and 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.

COMMUNITY AFFAIRS

(a)

DIVISION OF HOUSING AND DEVELOPMENT

New Home Warranties and Builder Registration Claims Procedure

Proposed Amendment: N.J.A.C. 5:25-5.5

Authorized By: Stephanie R. Bush, Commissioner, Department of Community Affairs.

Authority: N.J.S.A. 46:3B-10.

Proposal Number: PRN 1993-610.

Submit comments by December 15, 1993 to:

Michael L. Ticktin, Esq.
Chief, Legislative Analysis
Department of Community Affairs
CN 802
Trenton, NJ 08625
FAX #(609) 633-6729

The agency proposal follows:

Summary

This proposed amendment extends the inspection, bidding, hearing and assignment of rights rules that apply in cases of builder default to those cases in which an owner files a claim with the State New Home Warranty Security Plan after the two-year period in which the builder is required to warrant the home has expired.

Social Impact

Current rules ensure that only valid claims will be paid in cases of builder default and that payment will not be in excessive amounts. The proposed amendment would further protect the integrity of the New Home Warranty Security Fund, thereby making sure that it will have the resources to pay valid claims in the future, by establishing the same safeguards in cases of claims arising after the period in which the builder is responsible for correcting defects has ended.

Economic Impact

Protection of the integrity of the New Home Warranty Security Fund will be beneficial to legitimate claimants, both now and in the future, and detrimental to those who might use the current gap in the rules to gain unfair advantage.

Regulatory Flexibility Statement

This proposed amendment concerns procedures to be followed by owners of new homes in filing claims with the State New Home Warranty Security Plan. It does not affect "small businesses," as defined in the New Jersey Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. Thus, a regulatory flexibility analysis is not required.

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

5:25-5.5 Claims procedure

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

(g) All claims [which are] filed with the State Plan after the expiration of the first two-year warranty period shall be filed with and processed by the Division. All payments [occurring therein] **made by the Division on such claims** shall be from the New Home Warranty Security Fund.

1. Upon receipt of a claim, the Division shall inspect the home for the purpose of determining if the defect is covered by the warranty and, upon verification that the defect is covered, and upon submission of the bids and review thereof as provided in (e)2 above, the Director shall certify the amount of the award to the Treasurer, who shall make payment from the fund.

2. The provisions of (e)2, 3 and 4 above shall apply in all cases in which claims are filed with the State Plan after the expiration of the first two-year warranty period.

HUMAN SERVICES

(a)

DIVISION OF YOUTH AND FAMILY SERVICES

Manual of Requirements for Child Care Centers

Proposed Repeal and New Rules: N.J.A.C. 10:122

Authorized By: William Waldman, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:5B-1 to 15.

Proposal Number: PRN 1993-621.

Submit comments in writing by December 15, 1993 to:

Richard Crane, Acting Chief
Bureau of Licensing
Division of Youth and Family Services
CN 717
Trenton, New Jersey 08625-0717

The agency proposal follows:

Summary

Pursuant to the State Child Care Center Licensing Law (N.J.S.A. 30:5B-1 to 15), amended by recent legislation (P.L. 1992, c.95), the authority of the Department of Human Services to license child care centers has been extended to include centers serving six or more children up to, but not including, 13 years of age. Previously, the Department was authorized to license centers serving six or more children up to, but not including, six years of age. The new law took effect on March 10, 1993. The Division of Youth and Family Services (DYFS), through its Bureau of Licensing, administers the child care licensing program.

In expanding the scope of licensing to apply to programs serving children up to the age of 13 years, the Division recognized the various needs of children of different ages and developmental levels, and the differences in the programs offered to them, and sought to differentiate between the rules appropriate for best meeting the needs of children in early childhood programs and those children in before- and after-school programs. Other amendments to the law also required new rules. The revisions to the existing rules necessitated by the legislative amendments are extensive to the point that the Division proposes to repeal the existing rules and adopt new rules, even though the rules governing early childhood programs remain essentially unchanged.

The Division formed a Citizens Ad Hoc Advisory Committee to ensure community participation in the development of new rules. The Advisory Committee included directors and staff of several programs serving school-age children; representatives from local government-sponsored recreation and park programs serving school-age children; representatives of child care advocacy organizations, including the New Jersey Child Care Advisory Council, the New Jersey School-Age Child Care Coalition, and the New Jersey Association for the Education of Young Children; and representatives from other appropriate State government agencies. The Committee membership was carefully selected in order to assure a broad range of viewpoints, knowledge and experience in formulating the new licensing rules. To secure additional input, the Division held three public meetings in May, 1993, at three regional locations—Glassboro, Edison and Wayne. DYFS and Bureau of Licensing managers also made presentations to the New Jersey Child Care Advisory Council and a number of other State child care organizations and conferences.

Instead of proposing amendments to the existing rules, the Division determined that repealing the existing rules and proposing new rules would be the best way to promote clarity and prevent confusion by the licensees. The proposed rules have been formatted to identify easily both types of programs and the rules that apply specifically to each program. Each subchapter includes generic rules that apply to all centers and, where applicable, follows with a section describing those rules that apply only to early childhood programs. Where appropriate, a final section describes the rules applicable only to school-age child care programs. This school-age section contains the most significant changes to the rules, as the nature of school-age programs differs markedly from early childhood programs. The following summary provides an overview of the subchapters and highlights those new rules that reflect substantial revisions or additions to existing rules.

Subchapter 1. General Provisions

Subchapter 1 (N.J.A.C. 10:122-1) cites the legal authority for the rules and extends the age limit for licensing child care centers from six years to 13 years (N.J.A.C. 10:122-1.1), as required by the amended law. In keeping with P.L. 1992, c.95, the Division is authorized to issue Certificates of Life/Safety Approval, for the first time, to centers that operate on a seasonal or short-term basis (for eight weeks or less) and do not offer a continuous program that extends across the three-year period of licensure (N.J.A.C. 10:122-1.1). Until now, such Certificates have only been issued to centers operated by an aid society of a properly organized and accredited church that began operating on or before May 16, 1984. All centers eligible for such Certificates will be required to comply only with the physical facility, life/safety, administration and control of medication, environmental sanitation and communicable disease reporting provisions of the manual of requirements.

This subchapter also provides the definitions of terms used throughout the manual. The term "child care center" is defined to include programs serving children up to 13 years of age, in keeping with the amended law (see N.J.A.C. 10:122-1.2). The provisions for excluding programs from the definition of a "child care center" now allow for the exclusion of programs that offer activities for children who attend at their own discretion on an "open door" basis, where there is no agreement, written or implied, between the program and the parent for the program to assume responsibility for the care of the child. Programs of specialized activities or instruction for children that are not designed or intended for child care purposes, including, but not limited to, Boy Scouts, Girl Scouts, 4-H Clubs, and Junior Achievement, and single activity programs such as athletics, art, music and dance instruction have been added to the list of programs exempt from licensure. Pursuant to the amended law, the exemption for foster homes, group homes and other children's residential facilities is deleted and an exemption is added for Department of Education programs for handicapped infants and/or preschool children.

Definitions of "early childhood program" and "school-age child care program" have been added to the definitions of other terms (N.J.A.C. 10:122-1.3). An "early childhood program" is defined as a supervised group program serving six or more children under six years of age. A "school-age child care program" is defined as a supervised group program serving six or more children under 13 years of age who are enrolled in a public or private school, when their classes are not in session. The term "school-age child care program" also includes programs that serve kindergarten children before and/or after their regular school session and pre-kindergarten children before and/or after their regular school session, if the pre-kindergarten children attend the program for no more than three and a half hours. Criteria for determining when programs are excluded from the definitions of "child care center," "early childhood program" and "school-age child care program" are clarified.

This subchapter also adresses the hours a center is permitted to provide child care (N.J.A.C. 10:122-1.4). As in the existing manual, center hours of regular operation are limited to no more than 12 hours within a 24-hour period for centers operating during normal waking hours and no more than 16 hours for centers operating during normal sleeping hours.

Subchapter 2. Licensing Procedures

Subchapter 2 (N.J.A.C. 10:122-2) outlines licensing procedures. It describes the steps for securing a child care center license or Certificate of Life/Safety Approval, the application process, and the licensing fees ranging from $100.00 to $200.00, based on center size. New provisions make a flat fee option of $100.00 (regardless of center size) available to school-age child care programs that do not charge a fee or require other compensation or services from parents, and to programs operating for eight weeks or less each year that qualify for a Certificate of Life/Safety Approval (N.J.A.C. 10:122-2.1). Rules regarding issuance of regular and temporary licenses (N.J.A.C. 10:122-2.2), physical location of a center (N.J.A.C. 10:122-2.3), the criteria for denying, revoking, suspending and refusing to renew a license (N.J.A.C. 10:122-2.4), administrative hearings (N.J.A.C. 10:122-2.5), complaints (N.J.A.C. 10:122-2.6), and public access to the Bureau's licensing records (N.J.A.C. 10:122-2.7) are also contained in this subchapter, and have not been changed from those in the existing manual. This subchapter also clarifies procedures for securing a Certificate of Life/Safety Approval and specifies the provisions that these centers must meet, based on the amended law (N.J.A.C. 10:122-2.8).

Subchapter 3. Center Administration

Subchapter 3 (N.J.A.C. 10:122-3) describes the administrative responsibilities of center sponsors (N.J.A.C. 10:122-3.1), reporting requirements (N.J.A.C. 10:122-3.2), and specific recordkeeping rules for administrative, staff and children's records; insurance policies; fire drill logs; staff training records; and other documents. The existing requirement for documentation of the director's daily unannounced visits to each group of children has been deleted.

A new requirement now allows centers to keep the records for children who are no longer enrolled at the center at either a central administrative office or at the center (N.J.A.C. 10:122-3.3(d)2). The existing manual requires these records to be kept only at the center. Early childhood programs must continue to meet the recordkeeping requirements of the existing manual for written policies on the toilet training of children; plans for the feeding schedules, formulas, and nutritional needs of children under 18 months of age; and records of visits by consulting head teachers (N.J.A.C. 10:122-3.3(e)). Records must be maintained for one year after the staff person or the child leaves the center. This subchapter also continues the existing requirements for centers to have comprehensive general liability insurance (N.J.A.C. 10:122-3.4) and their own telephone or ready access to a telephone (N.J.A.C. 10:122-3.5). New conditions for centers without their own telephone are specified. Centers must continue to have a document providing specified information to parents, in order to prevent child abuse/neglect (N.J.A.C. 10:122-3.6).

Subchapter 4. Staff Requirements

Subchapter 4 (N.J.A.C. 10:122-4) describes the requirements for center staff. General requirements for all staff continue as in the existing manual, including: character and fitness to perform the job satisfactorily; application and basic identification information; references; disclosures of criminal convictions; and disclosure of previous denial, suspension, revocation or non-renewal of a center's license (N.J.A.C. 10:122-4.1). Centers must have a sponsor and a director and must meet specific staffing requirements regarding types and numbers of staff (N.J.A.C. 10:122-4.2). In addition, centers must have adequate staff to meet the applicable staff/child ratio requirements. Based on center capacity, early childhood programs are required to have one or more head teachers, group teachers and consulting head teachers (N.J.A.C. 10:122-4.2(b)); and, for the first time, school-age child care programs are required to have one or more program supervisors at each site (N.J.A.C. 10:122-4.2(c)). Charts specifying the number of head teachers, consulting head teachers, group teachers and program supervisors required, based on center capacity, are provided (N.J.A.C. 10:122-4.2(b) and (c)).

Staff/child ratio rules require that children be supervised by a staff member at all times (N.J.A.C. 10:122-4.3). For children below six years of age, the staff/child ratio requirements remain the same as in the existing manual; for children six years of age and older, a staff/child ratio requirement of one staff for every 18 children has been added. Minimum numbers and ages of staff are also addressed in this section of the subchapter. Early childhood programs must continue to meet the existing requirements for a minimum of two staff members, at least one of whom is 18 years of age, to be at the center and involved in the care of children when six or more children under six years of age are present, unless staff/child ratio requirements call for additional staff. For early childhood programs, staff members must be at least 14 years of age to be counted in the staff/child ratio (N.J.A.C. 10:122-4.3(k)). New rules for school-age child care programs permit one staff member to supervise up to 12 children under certain specific conditions. For school-age child care programs, staff members must be at least 16 years of age to be counted in the staff/child ratio (N.J.A.C. 10:122-4.3).

Staff responsibilities specified in the existing manual are continued in this subchapter (N.J.A.C. 10:122-4.4). The director must ensure: compliance with the manual; supervision of staff; development and implementation of policies; staff orientation and training; maintenance of records and files; and coverage of specified staff positions during absences. Specific responsibilities are delineated for the sponsor, director, head teacher, group teacher and program supervisor. The head teacher in early childhood programs and the program supervisor in school-age child care programs must be scheduled to work for at least 75 percent of the program's operating hours, and are responsible for ensuring: the development and implementation of the center's child development and activities program; and the provision of program activities that are appropriate for the age and developmental level of the children.

General and specific staff qualification requirements are described, and charts listing the options available for meeting the qualification requirements for director, head teacher, and program supervisor are included (N.J.A.C. 10:122-4.5). Head teachers and group teachers in early childhood programs continue to be required to have both education and experience in the early childhood field. Staff qualification requirements in school-age child care programs increase based on center capacity. New rules for program supervisors in school-age child care programs require less intensive education qualifications, including training in child care and program management. Program supervisors must have experience with school-age children. These differences in required staff qualifications between the two types of programs are based on the differences in the developmental and programming needs of children enrolled in early childhood and school-age child care programs.

Rules regarding grouping of children (N.J.A.C. 10:122-4.6) specify a maximum group size of 20 for early childhood programs and 30 for school-age child care programs. These limits do not apply during naps, meals, outdoor activities and specially scheduled events.

Subchapter 4 also continues the existing rules requiring staff to be trained in specific areas of the manual (N.J.A.C. 10:122-4.7), including: implementing the center's discipline policy; recognizing and reporting child abuse and neglect; supervising children; implementing health practices; evacuating the center; using the fire extinguisher and fire alarms; implementing the center's release policy; planning and providing for age-appropriate activities; and requiring centers to give staff members a copy of the Information to Parents document.

Both early childhood programs and school-age child care programs must meet special requirements to prevent child abuse and neglect (N.J.A.C. 10:122-4.8), such as reporting possible abuse/neglect to the Division, and removing staff members found by the Division to pose a risk of harm to children.

Subchapter 5. Physical Facility Requirements

Subchapter 5 (N.J.A.C. 10:122-5) describes the physical facility requirements for centers, including those required by State, county and municipal governments (N.J.A.C. 10:122-5.1). The necessary government approvals—Certificate of Occupancy, fire safety inspection certificate, satisfactory health approval, and health letter for hospital-based centers—continue to be required. In addition to the use groups applicable under the Uniform Construction Code (N.J.A.C. 5:23) for early childhood programs in the existing manual, school-age child care programs will be permitted the option of an A-3 or A-4 (Assembly) use group.

School-age programs located in buildings constructed prior to January 1977 are required to obtain either a Certificate of Continued Occupancy, as required for early childhood programs, or a valid fire safety inspection certificate based on an inspection conducted within the preceding 12 months.

Physical plant requirements are also addressed in this subchapter (N.J.A.C. 10:122-5.2). This section covers the equipment and procedures necessary to ensure basic standards for indoor and outdoor maintenance, sanitation and safety. The proposed rules continue to specify the number of toilets and sinks required in a licensed center, but no longer require sinks to be located in bathrooms in newly constructed buildings (sinks may be located elsewhere, such as in classrooms). Rules governing annual staff training in the use of fire extinguishers and evacuation procedures have been clarified (N.J.A.C. 10:122-5.2(o)).

Differential physical facility requirements for school-age and early childhood programs have been specified. Only early childhood programs are required to meet requirements (N.J.A.C. 10:122-5.2(s)) regarding: protective covers for electric outlets accessible to children; insect screening for indoor spaces using natural ventilation; provision of hot tap water not exceeding 110 degrees; lally columns padded to a height of 48 inches; use of kitchens for children's program activities; protective barriers to prevent children from accidentally entering kitchens and other food preparation areas; size and safety of outdoor space; and barriers for areas with an open drop or atrium. School-age child care programs must meet requirements (N.J.A.C. 10:122-5.2(t)) regarding: privacy of children when using the toilet; protective padding to a height of 72 inches for lally columns; insect screening for centers that serve food; and provision of hot tap water not exceeding 120 degrees. The provisions for determining the minimum square feet of usable indoor space for each child, and the minimum number of sinks and toilets in the center, are more flexible for school-age child care programs than for early childhood programs.

Special physical facility and monitoring requirements to prevent child abuse and neglect are detailed in this subchapter (N.J.A.C. 10:122-5.3).

As in the existing manual, minimum lighting levels are set and locking of doors in rooms designated for use by children is prohibited (N.J.A.C. 10:122-5.3(a) and (b)). Monitoring requirements (N.J.A.C. 10:122-5.3(c)) for school-age child care programs and most early childhood programs include a range of options promoting maximum visibility and audibility, from a central audio or visual monitoring system to ensuring that an interior door is left open. Monitoring requirements for early childhood programs located in newly constructed buildings that seek to serve 16 or more children have not been changed (N.J.A.C. 10:122-5.3(e)). Existing requirements are continued to prevent adults and children from using the same toilet facility at the same time (N.J.A.C. 10:122-5.3(d)1).

Subchapter 6. Program Requirements

Subchapter 6 (N.J.A.C. 10:122-6) describes the program requirements for centers. As in the existing manual, centers are required to develop and provide a variety of planned activities geared to the age and developmental level of the children served (N.J.A.C. 10:122-6.1(a) and (b)). A provision is added requiring that children riding bicycles wear helmets (N.J.A.C. 10:122-6.1(c)), as specified in the Bicycle Helmet Law, N.J.S.A. 39:4-10.1. Early childhood programs must continue to meet specific requirements to provide outdoor experiences and certain developmental activities for children (N.J.A.C. 10:122-6.1(f)). School-age child care programs (N.J.A.C. 10:122-6.1(g)) are required to provide activities geared to the interests and skill levels of the children served, opportunities for child involvement in activity planning, and self-selected activities. As school-age children are generally given other opportunities for outdoor activities at school, school-age programs are not required to provide outdoor experiences but are required to offer a mixture of indoor/outdoor and large muscle activities.

To meet program equipment requirements, centers must provide a supply of age- and developmentally-appropriate program equipment, including play equipment and appropriately sized furniture and supplies (N.J.A.C. 10:122-6.2).

Food and nutrition requirements are also addressed in this subchapter (N.J.A.C. 10:122-6.3). General requirements for the provision, storage, preparation and serving of food continue as in the existing manual. Centers must advise parents of repetitive feeding problems; ensure that no child is forced or coerced to eat; make drinking water available; make provision for special diets; and post individualized, written diets and feeding schedules submitted by the parents or a physician (N.J.A.C. 10:122-6.3(a)).

Early childhood programs must continue to have a working refrigerator if the center operates for more than three consecutive hours (N.J.A.C. 10:122-6.3(b)1), inspect food for spoilage before serving (N.J.A.C. 10:122-6.3(b)2), and meet additional specific age-related requirements regarding: feeding supplies, equipment and procedures; scheduling of meals and snacks; and food groups to be included in meals and snacks (N.J.A.C. 10:122-6.3 and 6.4). School-age programs must meet additional specific requirements regarding: refrigeration of perishable foods and medicine (N.J.A.C. 10:122-6.3(c)1); serving of snacks to all children attending on an after-school basis (N.J.A.C. 10:122-6.3(c)2); and serving of meals on days when school is not in session (N.J.A.C. 10:122-6.3(c)3).

The rest and sleep requirements in this subchapter (N.J.A.C. 10:122-6.4) apply only to early childhood programs. These rules address the need to provide young children with appropriate opportunities for sleep, sanitary bedding and adequate equipment for sleep and rest.

This subchapter also requires centers to maintain a written policy on the release of children (N.J.A.C. 10:122-6.5), which must include the names of authorized persons to whom a child may be released and contingency plans in the event the child is not picked up. The release policy is expanded for school-age child care programs by requiring written authorization from the parent before a child can be released without supervision (N.J.A.C. 10:122-6.5(b)).

As in the existing manual, discipline and guidance methods used in all centers must be positive, consistent with the age and developmental needs of the children and lead to the child gaining the ability to maintain self-control (N.J.A.C. 10:122-6.6(a)). School-age child care programs are required to permit child participation in the development of discipline rules or to establish procedures to inform children of rules (N.J.A.C. 10:122-6.6(f)). This subchapter also describes special requirements to prevent child abuse and neglect, and inappropriate staff behaviors towards children (N.J.A.C. 10:122-6.7).

Center policies and procedures to encourage and provide for parent and community participation continue to be required (N.J.A.C. 10:122-6.8). Both early childhood and school-age programs are given a range of options for meeting these requirements. However, school-age child care programs may meet the requirements by only providing individual parent/staff conferences, while early childhood programs must provide additional means of parent involvement/participation (N.J.A.C. 10:122-6.8(i)1). School-age child care programs must meet an additional requirement to advise parents of the center's policy for serving meals and snacks on days when school is not in session (N.J.A.C. 10:122-6.8(i)2).

Subchapter 7. Health Requirements

Subchapter 7 (N.J.A.C. 10:122-7) describes the health requirements for centers. Requirements for illness/communicable disease policies and procedures remain the same as in the existing manual (N.J.A.C. 10:122-7.1). Provisions permitting attendance by children and staff known to be infected with HIV (N.J.A.C. 10:122-7.2) have been changed by removing the existing requirement excluding infected children who exhibit biting, drooling or incontinence, as recommended by recent guidelines developed by the New Jersey Department of Health.

Health and immunization requirements for children and staff continue to apply to early childhood programs, as in the existing manual. However, school-age child care programs are not required to obtain records of the children's health examinations and immunizations as specified for early childhood programs, since children must already provide these records as a condition of school attendance. School-age child care programs are required only to obtain written verification from parents, stating that the child is in good health and can participate in the normal activities of the program or identifying any special health conditions or needs that may require special accommodations (N.J.A.C. 10:122-7.3). Health and immunization requirements specific to county and municipal government recreation and park programs operating for four weeks or less, which are specified in the existing manual, have been removed, since the new law no longer requires short-term programs to meet these requirements. According to the law, centers operating on a short-term basis for eight weeks or less need only comply with the physical facility and life/safety requirements, and requirements for the administration and control of medication, environmental sanitation and reporting of communicable diseases.

Health requirements for staff members (N.J.A.C. 10:122-7.4) continue as in the existing manual, with the exception of the rule requiring a Mantoux tuberculin test to have been obtained within one year prior to hiring. This time limit has been deleted in the proposed new rules. Requirements for the administration and control of prescription and nonprescription medicines (N.J.A.C. 10:122-7.5) also remain substantially the same as in the existing manual. However, school-age child care programs are permitted to allow children to administer their own medication with parental permission and under staff supervision (N.J.A.C. 10:122-7.5(d)). The rule requiring centers choosing not to administer medication to inform the parents of this policy at the enrollment conference is revised to require only that parents be informed prior to enrollment (N.J.A.C. 10:122-7.5(a)).

Rules regarding accidents and injuries to children (N.J.A.C. 10:122-7.6) and environmental sanitation and personal hygiene (N.J.A.C. 10:122-7.7 and 7.8) remain the same as in the existing manual, except that specific requirements for toilet training, feeding equipment, removal of poisonous plants, and diapering facilities and equipment will apply only to early childhood programs (N.J.A.C. 10:122-7.7(e) and 7.8(d)). The requirement for mats that are not stored separately to be washed and disinfected is clarified to apply only to mats used for sleeping (N.J.A.C. 10:122-7.7(a)3i(4)). The existing prohibition against smoking has been expanded to prohibit smoking in vehicles occupied by children (N.J.A.C. 10:122-7.7(d)). The illness log requirements now apply only to early childhood programs (N.J.A.C. 10:122-7.9). Requirements for reporting of illnesses, injuries and reportable diseases (N.J.A.C. 10:122-7.10) and information to parents regarding management of communicable diseases (N.J.A.C. 10:122-7.11) continue as in the existing manual.

Subchapter 8. Requirements for Centers Serving Sick Children

Subchapter 8 (N.J.A.C. 10:122-8) describes the requirements for child care centers serving sick children, including general requirements for such centers (N.J.A.C. 10:122-8.1); admission criteria (N.J.A.C. 10:122-8.2); additional staff (N.J.A.C. 10:122-8.3); special physical facilities (N.J.A.C. 10:122-8.4); program activities (N.J.A.C. 10:122-8.5); sanitation and infection control (N.J.A.C. 10:122-8.6); and additional records (N.J.A.C. 10:122-8.7). Staff/child ratio requirements for centers

serving sick children are revised to include children six years of age and older (N.J.A.C. 10:122-8.3(c)). Other rules for care of sick children continue as in the existing manual.

Subchapter 9. Transportation Requirements

Subchapter 9 (N.J.A.C. 10:122-9) describes the transportation requirements for child care centers. Requirements regarding use of private vehicles (N.J.A.C. 10:122-9.1) and vehicle definitions (N.J.A.C. 10:122-9.2) continue as in the existing manual. Requirements for vehicles used by early childhood programs remain the same as in the existing manual but have been recodified for clarity. Vehicle requirements for school-age child care programs that transport children have been added (N.J.A.C. 10:122-9.3(b)).

Driver licensing requirements (N.J.A.C. 10:122-9.4) now require that school-age child care programs using vehicles with a capacity of 17 or more passengers ensure that drivers possess the required commercial driver's license (N.J.A.C. 10:122-9.4(b)). Vehicle-related safety practices (N.J.A.C. 10:122-9.5) are also addressed in this subchapter. Smoking is prohibited in vehicles occupied by children (N.J.A.C. 10:122-9.5(l)). Early childhood programs must continue to ensure that children are released to an authorized person when leaving the vehicle (N.J.A.C. 10:122-9.5(m)). School-age programs transporting 12 or more children must have a minimum of one adult in addition to the driver in each vehicle (N.J.A.C. 10:122-9.5(n)). Vehicle insurance rules (N.J.A.C. 10:122-9.6) remain the same as in the existing manual. Transportation record requirements now include a requirement for school-age programs to obtain written authorization from the parents before transporting children (N.J.A.C. 10:122-9.7(h)). Special requirements for transporting physically handicapped, non-ambulatory children (N.J.A.C. 10:122-9.8) continue as in the existing manual. Special requirements for the prevention of child abuse and neglect (N.J.A.C. 10:122-9.9), which require additional staff members on vehicles for certain numbers and ages of children, will apply only to early childhood programs.

Social Impact

The proposed rules will have a positive impact by providing, for the first time in New Jersey, the safeguard of licensure for school-age child care programs. Parent-consumers and children enrolled in child care programs will have the assurance of receiving both school-age and early childhood child care services from providers who are regulated by the Division of Youth and Family Services, Bureau of Licensing. Providers of child care will be required to apply for a license, subject to inspection by the Bureau of Licensing, and required to comply with minimum standards. In addition to licensing school-age child care programs, the Bureau will provide these programs with technical assistance to enable them to meet these requirements, a service the Bureau now provides for early childhood programs. The Division estimates that as many as 1,000 school-age child care programs will be subject to licensure. The Division now licenses more than 2,350 child care centers, with a capacity to serve approximately 144,400 children.

Providers who offer only school-age child care programs are new to the licensing process, and may need to modify some of their existing management procedures and/or program offerings to qualify for licensure. Those providers who offer both early childhood and school-age child care programs will experience little or no social impact from the new rules, as their early childhood programs are already licensed. The inspection process now in place will be extended to include their school-age programs as well.

A positive social impact will also result from the proposed changes in the requirements for children infected with HIV (Human Immunodeficiency Virus). The current rules require centers to exclude such children when they exhibit certain behaviors formerly thought to spread HIV, including biting, drooling and incontinence or not being toilet trained. Although this requirement was based on the best available medical knowledge at the time the existing manual was adopted, it is no longer necessary, since new medical research shows that these behaviors do not spread HIV and do not justify exclusion of a child from group care. The proposed new rules recommend, but do not require, that centers admit children known to be infected with HIV on the same basis as other children. A child who exhibits certain symptoms of illness is required to be excluded from the center, whether or not the child has HIV. These new rules may help HIV-infected children receive appropriate child care when they pose no risk to others in the center.

The new rule requiring children riding bicycles to wear helmets will also have a positive social impact. This rule is necessary to comply with recent legislation (N.J.S.A. 39:4-10.1) designed to protect children from head injuries. Children and parents will be more aware that helmets must be used consistently, when riding bicycles both at the center and at home, so that helmet use becomes a safety habit.

A positive social impact will also result from prohibiting smoking in vehicles occupied by children. This rule expands the existing prohibition against smoking in rooms and outside areas occupied by children, in order to protect children from the health risk of environmental tobacco smoke.

Economic Impact

The proposed new rules will have some economic impact on school-age child care programs, especially those that are new to licensure. However, the Division was careful to consider the economic impact of each requirement and sought, wherever possible, to minimize that impact and to provide a range of options for compliance with the new rules.

Licensed child care centers are required to pay a licensing fee every three years, based on the center's licensed capacity (the maximum number of children permitted at one time). The current fees range from $100.00 to $200.00, and no increase is proposed. The annual cost ranges from $34.00 to $67.00, and the added weekly cost per child will be only a few cents (three cents to six cents per week). The Division has made provisions for accommodating those school-age child care programs that do not charge fees for services (or other forms of compensation) by charging them a flat $100.00 licensing fee, rather than the progressive capacity-based fee charged to other centers. Nevertheless, some providers may object to these fees, particularly when care is provided at multiple sites under the same sponsorship. Since each site receives a separate license, the sponsor will be required to pay a licensing fee for each site. The total cost to the sponsor could amount to hundreds or thousands of dollars in some instances, although the cost per child remains low.

Centers may also experience some economic impact from the new staffing requirements for school-age child care programs. Each center will be required to employ a program supervisor who meets specified qualifications for education and experience. These qualifications are based on center capacity, so that smaller centers may use staff with less education and experience. The Division expects that current staff in most centers will already meet the qualifications or will be able to obtain the necessary education or experience easily. The qualifications for program supervisor allow for a range of experience and education options. Staff members with only a high school diploma and no college credits can qualify as program supervisor by documenting past experience and completing the required clock hours of training in child care and, in some cases, program management. Such training is available Statewide at little or no cost through community organizations and conferences, including training programs funded by the Division, which are available to staff of licensed centers without charge.

The new requirements for staff/child ratios and group size limits may also have an economic impact on some school-age child care programs. Centers must have one staff member for every 18 children aged six to 13 years, and must limit group size to 30 children in most cases. These requirements are more lenient than those for early childhood programs, since school-age children do not need the same degree of close supervision as preschool children. In addition, school-age programs will be permitted to have only one staff member present in certain circumstances for up to 12 children, while early childhood programs need two staff members present for six or more children. Some centers may find it necessary to hire additional staff to meet these requirements. However, the requirements are necessary since research shows that limits on staff/child ratios and group size are essential for the children's safety and welfare.

Some physical facility requirements may also have an economic impact on school-age child care programs. All newly licensed centers must have 35 square feet of indoor space per child, which will determine the center's licensed capacity. The Division's experience indicates that most school-age child care programs already meet this requirement. Centers must also provide monitoring methods to reduce the risk of child abuse/neglect by ensuring that children's activities are open to view. The current rules permitting inexpensive options to meet the monitoring requirements in some early childhood programs will be extended to all school-age child care programs as well. These programs will be permitted to select inexpensive monitoring methods such as leaving a door open, installing windows or cutouts in a door, using a dutch door with the top half open, or removing a door.

Certain physical facility requirements will be reduced or eliminated for school-age child care programs in order to minimize the economic impact. For example, bathrooms in school-age child care programs may be located one floor above or below the floor levels used by children. The only physical facility requirement that is stricter for school-age programs than for early childhood programs is the requirement for padding around lally columns. Since school-age children are taller than preschool children, higher padding is necessary to prevent injury.

The rules for food and nutrition will have limited economic impact on school-age child care programs. When children attend after school, the center will be required to serve snacks. When children attend on days when their school is not in session, the center will be required to serve meals. In both cases, the center may choose to prepare the food on site, purchase food from a caterer, or have parents supply the food. The center is required to have a refrigerator only if perishable food or medication is stored on site. The Division expects that most school-age programs already meet these requirements, or will be able to meet them at little or no cost. These requirements are necessary for the children's health and safe food service.

The requirements for health and sanitation will also have limited economic impact. School-age child care programs must keep a first-aid kit and manual at each site, and provide a supply of soap and towels for handwashing. Staff members must submit documentation of a physician's examination and tuberculin Mantoux test, usually obtained at the staff member's expense. The one-year time limit for Mantoux tests to be completed by staff before hiring has been deleted, since a single negative Mantoux test is a reliable indicator of the absence of tuberculosis. School-age programs will not be required to keep records of each child's immunizations and physician's examination, as these records are already on file at the child's school. School-age programs need only obtain a written statement from parents describing the child's health status and any conditions that may require special accommodations. These health requirements are expected to be easily met by school-age programs.

Those school-age child care programs that provide transportation may experience a modest economic impact from the proposed transportation requirements. Additional safety equipment may need to be purchased for the vehicles used, such as a first-aid kit, fire extinguisher and reflectors. However, most school-age programs will be permitted to continue to use their existing vehicles and staff to transport children. Some centers may need to hire staff to provide the required second staff member in addition to the driver when transporting large groups of children. This requirement has been designed to minimize costs and recognize that school-age children need less supervision than preschool children. School-age programs will need a second adult only when transporting groups of 12 or more children. However, early childhood programs continue to need a second adult when transporting groups of four or seven children, depending on their ages, and need a third adult in some circumstances.

Some economic impact may result from the new rule requiring children to wear bicycle helmets. Centers that offer bicycling activities must either purchase helmets or require parents to supply them. Some parents may need to buy a helmet for their child's use at the center, but many parents will already have one for home use and can send the same one to the center with the child. To reduce costs, the center may choose to limit the numbers of children using bicycles, or provide other program options in place of bicycling activities.

A positive economic impact will result from deleting some recordkeeping requirements that have been burdensome to existing centers. Centers will no longer be required to document the director's daily unannounced visits to each group of children; the Bureau will verify that these visits have taken place by interviewing staff members. Centers will also no longer be required to store records at the center for children no longer enrolled; these records may be stored at an administrative office instead.

A positive economic impact will result from the proposed new rules for short-term/seasonal child care centers that operate for eight weeks or less. Until now, these centers have been required by law to be licensed, but in practice it has been difficult and costly for these centers to meet all the licensing requirements in such a short time. The amended licensing law now permits these centers to receive a certificate of Life/Safety Approval instead of a license, so that they will only be required to comply with the physical facility requirements and certain health requirements in the manual. This legislative amendment and the corresponding new rules will reduce costs significantly for these short-term programs, including both early childhood and school-age centers. In addition, the Division's staff costs will be contained somewhat by reducing the scope of inspections for these short-term programs.

The Division will find it necessary to hire additional inspectors for the increased workload generated by licensing school-age child care programs. The Division expects to add some 800 to 1,000 school-age child care programs to the 2,300 centers already licensed.

Regulatory Flexibility Analysis

The proposed new rules affect child care centers, all of which fall within the definition of a small business, as defined in the Regulatory Flexibility Act (N.J.S.A. 52:14B-16 et seq.), and require compliance with comprehensive reporting, recordkeeping and other requirements as delineated in the Summary. The cost of the requirements is discussed in the Economic Impact above. Furthermore, the manual provides differential requirements based on licensed capacity to assist smaller centers in meeting the requirements for licensure. For instance, school-age child care programs serving fewer than 16 children may hire a program supervisor with less education and experience than is required for larger programs. Similar differential staff qualifications for early childhood programs are specified in the current manual, and will be continued in the new rules. Even though additional requirements have been imposed on larger new centers, smaller new centers serving fewer than 16 children will continue to be permitted to meet less stringent physical facility requirements. The Division does not expect that centers will need to hire any professional services outside their own staff to comply with the rules.

In addition, the Division has developed and distributed a Technical Assistance Handbook, which assists licensed centers in complying with the rules. This publication, which parallels and serves as a companion document to the licensing manual, is given to all licensed centers. It contains sample forms that can be utilized to comply with the recordkeeping requirements; useful information on professional organizations, resource and referral services, colleges and universities offering early childhood degree programs, and resource materials; as well as clear-cut instructions, explanations, suggestions, management techniques and alternative means for complying with manual provisions. This handbook will be updated to reflect the new rules and will contain materials specifically designed to assist school-age child care programs that are subject to licensure for the first time.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 10:122.

Full text of the proposed new rules follows:

CHAPTER 122
MANUAL OF REQUIREMENTS FOR CHILD CARE CENTERS

SUBCHAPTER 1. GENERAL PROVISIONS

10:122-1.1 Legal authority

(a) This manual is promulgated pursuant to the Child Care Center Licensing Law, N.J.S.A. 30:5B-1 to 15, supplemented by P.L. 1992, c.95.

(b) Under the laws specified in (a) above, the Department of Human Services is authorized to:

1. License certain public and private child care centers that are maintained for the care, development or supervision of six or more children under 13 years of age for less than 24 hours a day;

2. Inspect and examine the physical plant or facilities and program of a child care center and inspect all documents, records, files or other data maintained pursuant to the above-referenced law during the center's normal operating hours and without prior notice; and

3. Request the appropriate State and local fire, health and building officials to conduct examinations and inspections to determine a center's compliance with State and local ordinances, codes and regulations. The inspections shall be conducted and the results reported to the Department within 60 days after the request.

(c) Under the laws specified in (a) above, the Department of Human Services is authorized to issue a Certificate of Life/Safety Approval to a center that:

1. Operates on a seasonal or short-term basis for eight weeks or less and does not offer a continuous program that extends across the three-year period of licensure; or

2. Was operating on or before May 16, 1984 and was exempt from the licensing provisions because it was operated by an aid society of a properly organized and accredited church.

(d) Centers specified in (c)1 and 2 above are required to comply only with the physical facility, life/safety, administration and control of medication, environmental sanitation and communicable disease reporting provisions of this manual of requirements. Centers with Certificates of Life/Safety Approval may secure regular licenses on a voluntary basis as long as they comply with all provisions of this manual of requirements.

(e) To be eligible for a license, a center shall demonstrate to the satisfaction of the Department of Human Services, or the duly authorized agency, that the center complies with all applicable provisions of this manual.

(f) All applicable requirements shall be met by all child care centers, unless the rules are specified as "for early childhood programs" or "for school-age child care programs."

(g) Responsibility for ensuring that centers comply with the provisions of the laws cited in (a) above and with provisions of this manual is hereby delegated by the Department of Human Services to the Division of Youth and Family Services, Bureau of Licensing.

(h) When a person intends to care for six or more children under 13 years of age, he or she shall apply for and secure from the Bureau a license to operate a child care center. Once licensed, the center is subject to all applicable provisions of this manual, even if the number and/or ages of the children attending the center at a particular time should fall outside the definition of a center, as specified in N.J.A.C. 10:122-1.2(a).

10:122-1.2 Definition of child care center

(a) "Child care center" or "center" means any home or facility, by whatever name known, which is maintained for the care, development or supervision of six or more children under 13 years of age who attend for less than 24 hours a day. For a facility that is located in a sponsor's home, the Bureau shall not count the children residing in the sponsor's name in determining whether the facility is serving the minimum number of children that would require it to be licensed as a center.

(b) The term, child care center, shall include, but not be limited to, day care centers; drop-in centers; night-time centers; recreation-type centers sponsored and operated by a county or municipal government recreation and/or park department or agency; day nurseries; nursery and play schools; cooperative child centers; centers for children with special needs; centers serving sick children; infant-toddler programs; school-age child care programs; employment-related centers; centers that had been licensed by the Department of Human Services prior to the enactment of the Child Care Center Licensing Act of 1984; and kindergartens that are not an integral part of a private educational institution or system offering elementary education in grades kindergarten through sixth, seventh or eighth.

(c) The term, child care center, shall not include the following programs, since they do not meet the definition of a child care center:

1. A program serving fewer than six children who are below 13 years of age;

2. A program, such as that located in a bowling alley, health spa or other facility, in which:

i. Each child attends on a drop-in basis for no more than two hours; and

ii. The parent of each child attending the program is in the same building, is readily accessible at all times on an on-call basis, and is able to resume control of the child immediately;

3. A child care program operating within a geographic area, enclave or facility that is owned and/or operated by the Federal government;

4. A family day care home that is registered pursuant to the Family Day Care Provider Registration Law, N.J.S.A. 30:5B-16 et seq.; and

5. Programs that offer activities for children who attend at their own discretion on an "open door" basis, where there is no agreement, written or implied, between the program and the parent for the program to assume responsibility for the care of the child.

(d) The following programs are exempt from licensure pursuant to the laws specified in N.J.A.C. 10:122-1.1(a):

1. Programs operated by the board of education of a local public school district which is responsible for their implementation and management;

2. Programs operated by, and whose employees are paid by, a private school which is run solely for educational purposes. Such programs shall include kindergartens, pre-kindergarten programs or child care centers that are an integral part of a private educational institution or system offering elementary education in grades kindergarten through sixth, seventh or eighth;

3. Centers or special classes operated:

i. Primarily for religious instruction. To qualify for an exemption from licensing under this provision, a center or special class must:

(1) Be an integral part of a bonafide church or religion;

(2) Serve only children who are two years of age or older;

(3) Provide a program that is composed primarily of religious instruction in which the curriculum is related to religious themes, stories and/or teachings; and

(4) For children under six years of age, operate and provide religious instruction for not more than two hours on any day; or

ii. For the temporary care of children while persons responsible for such children are attending religious services. To qualify for an exemption from licensure under this provision, a center or special class must:

(1) Provide care only for the children of participants in religious services that are an integral part of a bonafide church or religion;

(2) Be arranged by and responsible to the church or religion; and

(3) Provide child care only for the duration of time the services are in progress;

4. Programs of specialized activities or instruction for children that are not designed or intended for child care purposes, including, but not limited to: Boy Scouts, Girl Scouts, 4-H Clubs, and Junior Achievement, and single activity programs, such as: athletics, gymnastics, hobbies, art, music, dance and craft instruction, which are supervised by an adult, agency or institution. To qualify for an exemption from licensing under this provision, a program must:

i. Provide activities that are supervised on a full-time basis by an adult; and

ii. Provide only a single instruction or activity program. For children under six years of age, such single instruction or activity programs shall be limited to not more than two hours on any day;

5. Youth camps required to be licensed under the Youth Camp Safety Act of New Jersey, pursuant to N.J.S.A. 26:12-1 et seq. To qualify for an exemption from licensing under this provision, a program must have a valid and current license as a youth camp, issued by the New Jersey Department of Health. A youth camp sponsor who also operates a child care center shall also secure a license from the Bureau for the center;

6. Day training centers operated by or under contract with the Division of Developmental Disabilities within the Department of Human Services. To qualify for an exemption from licensing under this provision, a center must be operated and funded as a day training center by the Division of Developmental Disabilities, pursuant to N.J.S.A. 30:4-165.2 et seq.; and

7. Privately operated infant and preschool programs that are approved by the Department of Education to provide services exclusively to local school districts for handicapped children, pursuant to N.J.S.A. 18A:46-1 et seq.

10:122-1.3 Definitions of other terms

The following words and terms, when used in this manual, shall have the following meanings:

"Bureau" means the Bureau of Licensing, Division of Youth and Family Services, Department of Human Services.

"Chapter" means the rules contained in the Manual of Requirements for Child Care Centers, as specified in N.J.A.C. 10:122, which reflect provisions that constitute minimum baseline requirements below which no center that is subject to the authority of N.J.S.A. 30:5B-1 to 15 is legally permitted to operate.

"Child" means any person under 13 years of age.

"Denial of a license or a Certificate of Life/Safety Approval" means the withholding by the Bureau of an initial license or Certificate of Life/Safety Approval, for which a center has applied.

"Department" means the New Jersey Department of Human Services.

"Director" means the on-site staff member responsible for the daily operation and management of the center.

"Division" means the Division of Youth and Family Services, Department of Human Services.

"Early childhood program" means a supervised group program serving six or more children under six years of age.

"Parent" means a birth or adoptive parent, legal guardian, or any other person having responsibility for, or custody of, a child.

"Person" means any individual, agency, corporation, company, association, organization, society, firm, partnership, joint stock company, the State or any political subdivision thereof.

"Refusal to renew a license or a Certificate of Life/Safety Approval" means the non-issuance of a license or a Certificate of Life/Safety Approval by the Bureau to a center after its existing license or Certificate of Life/Safety Approval has expired.

"Regular Certificate of Life/Safety Approval" or "Regular Certificate" means a document issued by the Bureau to a center that is eligible for such approval, indicating that the center is in full compliance with the provisions of this manual specified in N.J.A.C. 10:122-1.1(c).

"Regular license" means a document issued by the Bureau to a center indicating that the center is in full compliance with all applicable provisions of this manual.

"Revocation of a license or a Certificate of Life/Safety Approval" means a permanent removal of a center's current license or Certificate of Life/Safety Approval to operate.

"School-age child care program" means a supervised group program serving six or more children under 13 years of age who are enrolled in a public or private school, when their classes are not in session. The term, school-age child care program, may also include programs that serve: kindergarten children before and/or after their regular school session; and pre-kindergarten children before and/or after their regular school session if the pre-kindergarten children attend the program for no more than three and a half hours.

"Shall" denotes a provision of this chapter that a center must meet to qualify for a license.

"Should" denotes a recommendation reflecting goals towards which a center is encouraged to work.

"Sponsor" means any person owning or legally responsible for operating a center.

"Staff member" or "staff" means any person(s) employed by or working for or at a center on a regularly scheduled basis. This includes full-time, part-time, voluntary, substitute, contract or consulting personnel, whether compensated or not.

"Suspension of a license or a Certificate of Life/Safety Approval" means a temporary removal of a center's current license or Certificate of Life/Safety Approval to operate.

"Temporary Certificate of Life/Safety Approval" or "Temporary Certificate" means a document issued by the Bureau to a center that is eligible for such approval, indicating that the center is in substantial compliance with the provisions of this manual specified in N.J.A.C. 10:122-1.1(c), provided that no serious or imminent hazard affecting the children exists in the center.

"Temporary license" means a document issued by the Bureau to a center that is in substantial compliance with the applicable provisions of this manual, provided that no serious or imminent hazard affecting the children exists in the center.

10:122-1.4 Hours of care

(a) Centers operating during the normal waking hours shall not care for a child on a regular basis for more than 12 hours within a 24-hour period.

(b) Centers operating during the normal sleeping hours shall not care for a child on a regular basis for more than 16 hours within a 24-hour period.

SUBCHAPTER 2. LICENSING PROCEDURES

10:122-2.1 Application for a license

(a) No person shall operate a center without first securing a license from the Bureau. Any person who operates a center that does not have a valid license, or who uses fraud or misrepresentation in obtaining a license or who advertises or provides any service not authorized by a valid license, or who violates any other provision of the laws specified in N.J.A.C. 10:122-1.1(a), is guilty of a crime of the fourth degree, pursuant to N.J.S.A. 30:5B-13.

(b) A person applying for an initial license or renewal license to operate a center shall submit a completed application form to the Bureau at least 45 days prior to the anticipated opening of the center or to the expiration of its existing regular license.

(c) An applicant for an initial or renewal license shall submit, with the completed application form, 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	175.00
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 Head Start center, pursuant to 42 U.S.C. 9381 et seq., or a school-age child care program that does not charge a fee or require other compensation or services from parents, 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) If the application is denied, or the center does not open, the Bureau will refund the licensing fee to the applicant.

(f) The licensing fee will not be refunded once the Bureau issues the center a license.

10:122-2.2 Issuance of a license

(a) The Bureau shall issue a regular license to a center that has achieved full compliance with all applicable provisions of this manual.

(b) If the Bureau determines that a center is in substantial compliance with, but does not meet all, applicable provisions of this manual, and provided that there is no serious or imminent hazard to the health, safety, well-being and development of the children, the Bureau shall issue a temporary license to the center and indicate in writing the steps the center must take to secure a regular license.

(c) A temporary license may be issued for a period not to exceed six months. The Bureau may issue as many temporary licenses as it deems necessary. However, a center shall not operate pursuant to temporary licenses for more than 18 months.

(d) Each licensing period, which may include the issuance of one or more temporary licenses and/or one regular license, shall be three years.

1. In determining the expiration date of the first regular license, the Bureau shall compute the three-year licensing period from the date of issuance of the first temporary or regular license.

2. In determining the expiration date of a renewal regular license, the Bureau shall compute the three-year licensing period from the date on which the center's previous regular license expired.

(e) The license shall be posted in a prominent location within the center.

(f) A center shall not make claims contrary to its license, either in advertising or in any written or verbal announcement or presentation.

(g) A facility or program caring for children shall not claim in advertising, or in any written or verbal announcement or presentation, to be a licensed center unless it has secured a license from the Bureau.

(h) A center shall not claim that it is licensed by any State department or agency other than the New Jersey Department of Human Services, or that it is accredited by any State department.

10:122-2.3 Location of a center

(a) The license shall be issued to a specific center sponsor at a specific location and shall not be transferable.

(b) When two or more buildings are, or will be, utilized to accommodate centers operated by the same sponsor, the sponsor shall apply to the Bureau for either:

1. A separate license for each center in each building; or

2. A single license covering all the buildings that comprise a single center, provided that:

i. The buildings are on the same or contiguous properties;

ii. The programs have the same director; and

iii. The Bureau determines that issuance of a single license would not be detrimental to the health, safety, well-being, and development of the children served.

(c) A center shall not be located near or adjacent to areas determined by the Bureau to be hazardous to the physical health and safety of the children.

(d) The requirements for co-location of a center within a multi-use building are as follows:

1. The sponsor of a center that is, or seeks to be, co-located in a multi-use building shall indicate on its application the nature of the co-location.

2. Prior to approving the site, the Bureau shall determine that the multi-use site does not pose a serious risk to the health, safety or well-being of the children.

3. The Bureau may require the center to:

i. Operate in a separate room, floor and/or section of the building;

ii. Have or use a separate entrance and/or toilet facility; and/or

iii. Meet any other physical plant, staffing, program or other operational requirements that are deemed necessary to protect the children from serious risk of harm stemming from the co-location.

4. The sponsor of a center that has been approved to be located in a multi-use building shall notify the Bureau of any change in use by other occupants of the building, as specified in N.J.A.C. 10:122-3.2(a).

10:122-2.4 Denying, suspending, revoking or refusing to renew a license

(a) The Bureau may deny, suspend, revoke or refuse to renew a license for good cause, including, but not limited to, the following:

1. Failure or refusal to comply with all applicable provisions of the laws specified in N.J.A.C. 10:122-1.1(a) and of this manual;

2. Violation of the terms and conditions of a license;

3. Use of fraud or misrepresentation in obtaining a license or in the subsequent operation of the center;

4. Refusal to furnish the Division with files, reports or records, as required by this manual;

5. Refusal to permit an authorized representative of the Division to gain admission to the center and/or to conduct an inspection or investigation during the center's operating hours;

6. Any activity, policy or staff conduct that adversely affects or presents a serious hazard to the education, health, safety, well-being or development of a child attending a center, or that otherwise demonstrates unfitness by a sponsor or staff member(s) to operate a center;

7. Failure to provide developmental activities that meet the physical, social, emotional and cognitive needs of the children served; or

8. Failure by the sponsor to secure and maintain on file criminal conviction disclosures, as specified in N.J.A.C. 10:122-4.1(b) and (c).

(b) The Bureau shall provide written notice to the sponsor if it intends to deny, suspend, revoke or refuse to renew its application for a license. The notice shall specify the Bureau's reasons for such action.

(c) If the Bureau suspends a center's license to prevent the imminent risk of harm to children served by the center, the Bureau may reinstate the suspended license upon the center's compliance with all applicable provisions of this manual.

(d) If the Bureau denies, revokes or refuses to renew a center's license, as specified in (a) above, the center shall be prohibited from reapplying for licensure for one year from the date of license denial, revocation or refusal to renew. After the one-year period has elapsed, the center may submit to the Bureau a new application for a license.

(e) Each license issued by the Bureau to a center is the property of the State of New Jersey. If the Bureau suspends or revokes a license, the center shall return the license to the Bureau immediately.

10:122-2.5 Administrative hearings

(a) If a center fails to comply with all applicable provisions of this chapter, the Bureau shall issue a directive ordering compliance. Prior to the Bureau's decision to deny, suspend, refuse to renew or revoke a center's license, the Bureau shall afford the center an opportunity to request an administrative hearing, 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.

(b) As long as the Division determines that the children are not at risk and no serious or imminent hazards exist, the Bureau may permit a center that has requested an administrative hearing, as specified in (a) above, to continue to operate until a final decision is rendered as a result of the hearing.

10:122-2.6 Complaints

(a) Whenever the Bureau receives a report questioning the licensing status of a program or center or alleging that a licensed center is violating provisions of this manual, the Bureau shall ensure that the allegation is promptly investigated to determine whether the complaint is substantiated.

(b) After the report of the investigation has been completed, the Bureau shall notify the sponsor in writing of the results of the investigation, pursuant to the State Public Records Law, N.J.S.A. 47:1A-1 et seq., except for any information not permitted to be disclosed pursuant to the State Child Abuse and Neglect Law, N.J.S.A. 9:6-8.10a.

(c) Whenever the Division, through its Bureau of Licensing, Institutional Abuse Investigation Unit or District Offices, conducts complaint investigations, the center shall cooperate with all Division investigators.

10:122-2.7 Public access to the Bureau's licensing records

Licensing files maintained by the Bureau are public records and shall be readily accessible for examination by any person, under the direction and supervision of the Bureau, except when public access to records is restricted, in accordance with the State Public Records Law or other applicable statutes.

10:122-2.8 Procedures for securing a Certificate of Life/Safety Approval

(a) A center that is eligible for a Certificate of Life/Safety Approval, as specified in N.J.A.C. 10:122-1.1(c), may apply for and secure such a Certificate from the Bureau by complying with all provisions of N.J.A.C. 10:122-2.1 through 2.8, except for 10:122-2.1(c) and (e); 10:122-5.1 through 5.3; and 10:122-7.5, 7.7 and 7.10.

(b) The applicant shall submit to the Bureau a $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 for a Certificate of Life/Safety Approval.

(c) When an applicant is the sponsor of a licensed child care center and seeks to operate a seasonal or short-term program, as specified in N.J.A.C. 10:122-1.1(c)1, at the same site, the applicant shall submit an application for a Certificate of Life-Safety Approval with no additional fee required. The sponsor shall receive both a license and a Certificate of Life-Safety Approval.

(d) The Bureau shall review the application form and accompanying materials and conduct an on-site inspection of the center to determine whether it meets all applicable provisions of this manual as specified in (a) above. The center is found to be in full compliance, the Bureau shall issue a Regular Certificate of Life/Safety Approval to the center. If the center is found to be in substantial compliance, and provided that there is no serious or imminent hazard to the

health, safety, well-being and development of the children, the Bureau shall issue a Temporary Certificate of Life/Safety Approval.

SUBCHAPTER 3. CENTER ADMINISTRATION

10:122-3.1 Administrative responsibility

(a) The sponsor shall be legally responsible and held accountable by the Bureau for the overall operation of the center and for ensuring the center's compliance with all applicable provisions of this manual.

(b) When the sponsor is an entity owned or operated by two or more individuals, the sponsor shall designate one of those individuals to represent the interests and act on behalf of the sponsor.

10:122-3.2 Reporting requirements

(a) The center shall notify the Bureau verbally of any of the following changes or events by the next working day after the center learns of their occurrence:

1. Injury or illness that results in the admittance to a hospital or death of a child, as specified in N.J.A.C. 10:122-7.10(b);

2. Occurrence of a reportable disease, as specified in N.J.A.C. 10:122-7.10(a);

3. Change in use by other occupants of a multi-use building in which the center is located, as specified in N.J.A.C. 10:122-2.3(d);

4. Permanent closing of the center;

5. Damage to the premises of the center caused by fire, accident or the elements;

6. Proposed use of emergency space including re-location or use of rooms not approved by local municipal officials or by the Bureau, as specified in N.J.A.C. 10:122-5.2(q); and

7. Any conviction(s) or guilty plea(s) of the sponsor, director or any staff member, as specified in N.J.A.C. 10:122-4.1(b)1 and (c)2.

(b) The center shall notify the Bureau verbally, within three working days, of any change(s) to the licensing information previously submitted to the Bureau on the completed application form, including, but not limited to, changes in location. The center shall notify the Bureau in writing within 30 calendar days of any such change(s).

10:122-3.3 Center records

(a) General requirements for center records are as follows:

1. The center's records shall be open for inspection by authorized representatives of the Bureau.

2. The center's records shall be open for inspection by authorized representatives of the Division's Institutional Abuse Investigation Unit (IAIU) and, provided that they may only secure information about children under the Division's supervision, Division caseworkers.

(b) Requirements for administrative records are as follows:

1. The administrative records specified in (b)2 and 3 below shall be maintained by the center until the end of the current licensing period.

2. The following records shall be maintained in files either at a central administrative office or at the center:

i. Comprehensive general liability insurance, as specified in N.J.A.C. 10:122-3.4;

ii. A record of:

(1) Monthly fire drills, as specified in N.J.A.C. 10:122-5.2(m)3; and

(2) Training sessions for staff members on the use of fire extinguishers and fire alarms and evacuation procedures, as specified in N.J.A.C. 10:122-5.2(o); and

iii. If the center provides transportation:

(1) Vehicle insurance, as specified in N.J.A.C. 10:122-9.6; and

(2) Transportation records, as specified in N.J.A.C. 10:122-9.7.

3. The following records shall be maintained in files located at the center:

i. A current manual;

ii. The building's fire safety inspection certificate, as specified in N.J.A.C. 10:122-5.1(b);

iii. The center's certificate or statement of satisfactory health approval, as specified in N.J.A.C. 10:122-5.1(c);

iv. The Life/Safety and Program Inspection/Violation and Complaint Investigation Summary reports from the Bureau, as well as any letters of enforcement or other actions taken against the center, that cover the current licensing period;

v. The documents providing information to parents, as specified in N.J.A.C. 10:122-3.6(a) and 7.11;

vi. A record of each parent's signature attesting to the receipt of the Information to Parents document, as specified in N.J.A.C. 10:122-3.6(a) and (b);

vii. Documentation of the use of extermination services, if applicable, as specified in N.J.A.C. 10:122-5.2(a)7;

viii. Signed blanket permission slips for walks and signed individual permission slips for field trips, outings or special events involving transportation of children away from the center, as specified in N.J.A.C. 10:122-6.8(d) through (f);

ix. A written policy on the disciplining of children by staff members, as specified in N.J.A.C. 10:122-6.6(d);

x. A written policy on the release of children, as specified in N.J.A.C. 10:122-6.5(a);

xi. A written policy providing for the direct involvement of parents of enrolled children in the center's operation and activities, as specified in N.J.A.C. 10:122-6.8(h) and (i)1; and

xii. A written outline of the center's daily activities, as specified in N.J.A.C. 10:122-6.1(e).

(c) The requirements for staff records are as follows:

1. The staff records specified in (c)2 and 3 below shall be maintained by the center for one year after the staff member has stopped working at the center.

2. The following records for the sponsor, director and all staff members shall be maintained in files located either at a central administrative office or at the center:

i. Applications for employment, as specified in N.J.A.C. 10:122-4.1(b)1 and (c);

ii. References on the director and staff members, as specified in N.J.A.C. 10:122-4.1(b)2;

iii. Documentation of applicable education and experience, as specified in N.J.A.C. 10:122-4.5(a) through (d);

iv. A record of each staff member's signature attesting to the receipt of the policy statement on the disciplining of children by staff members, as specified in N.J.A.C. 10:122-6.6(e);

v. A record of each staff member's signature attesting to the receipt of the Information to Parents document, as specified in N.J.A.C. 10:122-3.6(b); and

vi. Health information for staff members, as specified in N.J.A.C. 10:122-7.4.

3. Staff attendance sheets, as specified in N.J.A.C. 10:122-4.4(b)3i, shall be maintained in files located at the center.

(d) The requirements for children's records are as follows:

1. For children currently enrolled in the center, the records for each child, as specified in (d)3i through vi below, shall be maintained in files located at the center.

2. For children no longer enrolled in the center, the records for each child, as specified in (d)3i through vi below, shall be maintained for one year in files located either at a central administrative office or at the center.

3. The following records shall be maintained for each child by the center:

i. A signed application for enrollment, as specified in N.J.A.C. 10:122-6.8(a)1;

ii. Daily attendance records for children, as specified in N.J.A.C. 10:122-4.4(b)3ii;

iii. Records of the occurrence of any unusual incidents involving a child, as specified in N.J.A.C. 10:122-4.8(c);

iv. For a non-custodial parent:

(1) If applicable, written authorization from the custodial parent to allow visits by or releases to the non-custodial parent, as specified in N.J.A.C. 10:122-6.5(a)3; and

(2) If applicable, a court order denying access, or granting limited access, by a non-custodial parent to his or her child, as specified in N.J.A.C. 10:122-6.5(a)3;

v. Health information for children, as specified in N.J.A.C. 10:122-7.3; and

vi. Accident and injury records, as specified in N.J.A.C. 10:122-7.6(b).

(e) For early childhood programs, the following shall apply:

1. The following records shall be maintained in files located at the center until the end of the current licensing period:

i. A written policy on the toilet training of children, if applicable, as specified in N.J.A.C. 10:122-7.7(e)3iii; and

ii. A written plan on the feeding schedules, formulas, and nutritional needs of children under 18 months of age, if served by the center, as specified in N.J.A.C. 10:122-6.3(b)3.

2. The requirements for centers using a consulting head teacher to meet staffing requirements are as follows:

i. A record of the consulting head teacher's two monthly visits to the center, as specified in N.J.A.C. 10:122-4.4(f)3ii, shall be maintained in files located at the center; and

ii. The records specified in (e)2i above shall be maintained by the center for one year after the consulting head teacher is no longer visiting the center.

10:122-3.4 Comprehensive general liability insurance

The sponsor shall secure comprehensive general liability insurance coverage for the center and shall maintain on file a copy of the insurance policy.

10:122-3.5 Telephone requirements

(a) The center shall have:

1. Its own telephone; or

2. Access to a telephone located in the same building. Under this option a person shall be available to receive incoming calls to the center, transmit telephone messages to center personnel immediately and make outgoing calls for the center, as necessary.

10:122-3.6 Special requirements to prevent child abuse and/or neglect

(a) The center shall give to the parent(s) of every enrolled child and to every staff member a written document indicating that the center is required to:

1. Be licensed by the Bureau of Licensing, Division of Youth and Family Services;

2. Comply with all applicable provisions of the Manual of Requirements for Child Care Centers;

3. Post its license in a prominent location within the center;

4. Retain a current copy of the manual and make it available for parents' review;

5. Indicate how parents can secure a copy of the manual from the Bureau;

6. Make available to parents, upon request, the Bureau's Life/Safety and Program Inspection/Violation and Complaint Investigation Summary report(s) on the center, as well as any letters of enforcement or other actions taken against the center during the center's current licensing period;

7. Post a listing or diagram of those rooms and/or areas that have been approved by the Bureau for children's use;

8. Comply with the inspection/investigation functions of the Division, including the interviewing of staff members and children;

9. Afford parents the opportunity and time to review and discuss with the center director any questions or concerns about the policies and procedures of the center or whether the center is in compliance with all applicable provisions of the manual;

10. Advise parents that if they believe or suspect that the center is violating any requirement of the manual, they may report such alleged violations to the center sponsor or director or to the Bureau;

11. Afford parents of enrolled children an opportunity to participate in the center's operation and activities;

12. Afford parents of enrolled children the opportunity to visit the center at any time during the center's hours of operation to observe its operation and program activities without having to secure prior approval;

13. Provide parents with advance notice of any field trip, outing or special event involving the transportation of children away from the center, and, for each event, secure the written consent of the parent(s) before taking a child on such a field trip, outing or special event;

14. Post a copy of the center's written statement of policy on the disciplining of children by staff members in a prominent location within the center, and make a copy of it available to parents upon request;

15. Indicate through this document that any person who has reasonable cause to believe that a child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, or harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect or exploitation by any adult, is required by State law to report such allegations to the Division's Office of Child Abuse Control or any District Office immediately, and indicate that such reports may be made anonymously;

16. Indicate through this document how parents and staff members may secure information about child abuse and/or neglect from the Division;

17. Inform parents of the center's policy on the release of children;

18. Inform parents of the center's policy on dispensing medication; and

19. Provide parents with a copy of the center's policy on management of communicable diseases.

(b) The center shall comply with the requirements specified in (a) above by:

1. Providing the document to every parent upon enrollment of each child, and to every person upon becoming a staff member; and

2. Securing and maintaining on file a record of the parent's and staff member's signature attesting to receipt of the document.

SUBCHAPTER 4. STAFF REQUIREMENTS

10:122-4.1 General requirements for sponsor, director, and all staff members

(a) The sponsor, director, and every staff member shall:

1. Be of good character and reputation;

2. Be in sufficient physical, mental and emotional health to perform his or her job duties satisfactorily; and

3. Possess skills, attributes, and characteristics conducive to and suitable for sponsoring a center or dealing with children, as applicable.

(b) Prior to hiring or utilizing a director or a staff member who will be working at the center for at least 20 percent of the center's weekly operating hours, the sponsor and director, respectively, shall secure and maintain on file:

1. A signed application for employment from each individual, indicating the applicant's name, address and telephone number; education and work experience; and disclosure of the presence or absence of criminal conviction(s). The employment application shall be updated to indicate the reason for discontinuance of employment, if applicable; and

2. Two written and/or verbal references on each individual. These references shall be secured from former employers or other persons who have knowledge of the individual's work experience and/or education and who can attest to the individual's suitability to work with children. The verbal references shall be documented in writing by the sponsor or director.

(c) Prior to hiring or utilizing a staff member who will be working at the center for less than 20 percent of the center's weekly operating hours, the director shall secure and maintain on file, the applicant's:

1. Name, address and telephone number;

2. Signed statement disclosing the presence or absence of criminal convictions; and

3. References, as specified in (b)2 above.

(d) The sponsor shall:

1. Maintain on file, regarding himself or herself, the information specified in (c)1 and 2 above; and

2. Disclose to the Bureau, in writing, information about and circumstances surrounding any previous denial, suspension, revocation or non-renewal of a license to own or operate a center either by the Bureau or by the licensing agency of another state.

(e) Failure by a sponsor, director or other staff member to comply with the requirements specified in (a) through (d) above and/or any evidence demonstrating unfitness or unsuitability to fulfill the responsibilities and duties of his or her position or to serve or deal with children in an appropriate manner shall constitute grounds for one or more of the following actions:

1. Removal of the sponsor, director or other staff member from his or her position;

2. Reassignment to other duties that do not involve contact with children;

3. Termination from the center; and/or

4. Denial, refusal to renew, suspension or revocation of the center's license.

(f) Evidence of conviction for crimes of violence, anti-social behavior and/or child abuse and/or neglect shall be among those actions that are considered in determining an individual's fitness and suitability to serve as sponsor, director or staff member.

(g) Evidence of conviction of a crime, in itself, shall not automatically preclude an individual from serving as sponsor, director or staff member or from working in the center and shall not automatically result in the removal or termination of a sponsor, director or staff member. The center shall submit a written justification to the Bureau, documenting why it believes that the individual should not be precluded from working or holding a position at the center. The Bureau, after assessing the facts on a case-by-case basis, shall make the final determination, in keeping with the provisions of the State Rehabilitated Convicted Offenders Act, N.J.S.A. 2A:168A-1 et seq., which provides that a person convicted of a crime may not be disqualified or discriminated against by a licensing authority unless the conviction relates adversely to the occupation, trade, vocation, profession or business for which a license is sought.

(h) Evidence of a previous denial, suspension, revocation, or nonrenewal of a license, as sepcified in (d)2 above, shall not in and of itself result in an automatic disqualification of the prospective sponsor or sponsor to secure a license for another or the same center, but shall constitute grounds for the Bureau to investigate the circumstances that led to the original negative action and to make a determination as to whether to reject or process the new application for a license.

10:122-4.2 Staffing requirements

(a) Each center shall have the following staff members:

1. A sponsor, who may also serve as the director and/or as one of the staff members specified in (a)3 below;

2. A director, who may also serve as one of the staff members specified in (a)3 below;

3. One or more of the applicable qualified staff members, as specified in the charts in (b) and (c) below for each program type offered; and

4. Additional staff members, as necessary, to meet staff/child ratio requirements, as specified in N.J.A.C. 10:122-4.3.

i. If the center offers an early childhood program and a school-age child care program, but has fewer than six children in one of those programs, the center shall only be required to meet the staffing requirements of the program serving six or more children.

ii. If the center offers an early childhood program and a school-age child care program, and has fewer than six children in both programs, the center shall meet the staffing requirements in either (b) or (c) below.

(b) For early childhood programs, the following shall apply:

1. Based on center size, the center shall have one or more head teachers, group teachers, and/or consulting head teachers, as specified in the chart below:

TYPES OF STAFF MEMBERS REQUIRED AT EARLY CHILDHOOD PROGRAMS

Licensed Capacity	Head Teacher(s)		†Group Teacher(s)		Consulting Head Teacher
6-15	1	or	1	or	1
16-30	1	or	(1	and	1)
31-60	1				
61-120	1	and	1		
121-180	1	and	2		
181-240	2	and	2		
241-300	2	and	3		
301-360	3	and	3		
361-420	3	and	4		
421-480	4	and	4		
481-540	4	and	5		

†A staff member who meets the head teacher qualifications, as specified in N.J.A.C. 10:122-4.5(c), may be utilized for a required group teacher.

i. As an exception to the staffing requirements in the chart above, centers with a licensed capacity of from six to 30 children, 50 percent or more of whom have special needs as a result of a cognitive, socio-emotional or physical handicap or disorder, shall have a head teacher.

(c) For school-age child care programs, the following shall apply:

1. Based on center size, the center shall have one or more program supervisors at each site as specified in the chart below:

TYPES OF STAFF MEMBERS REQUIRED AT SCHOOL-AGE CHILD CARE PROGRAMS

Licensed Capacity	Program Supervisor(s)
6-180	1
181-360	2
361-540	3

10:122-4.3 Staff/child ratios

(a) The children shall be supervised by a staff member at all times, including during toileting procedures and walking through hallways, as appropriate for their ages and developmental needs.

(b) There shall be a minimum of two staff members accompanying children on any field trip, outing or special event involving the transportation of children away from the center, even when the appropriate staff/child ratios allow fewer than two staff members.

(c) The following staff/child ratios shall apply, except as specified in (d) through (f) below:

Age	Staff/Child Ratio
Under 18 months	1:4
18 months up to 2½ years	1:7
2½ years up to 4 years	1:10
4 up to 6 years	1:15
6 years and older	1:18

(d) The following staff/child ratios shall apply during rest or sleep, when the criteria listed in (d)1, 2 and 3 below are met:

Age	Staff/Child Ratio
Under 2½ years	1:10
2½ years and above	1:20

1. At least one staff member shall be physically present in the room or area in which children are napping and shall be able to summon other staff members without leaving the room or area.

2. A sufficient number of staff members shall be in the facility and readily accessible to ensure compliance with the staff/child ratios specified in (c) above.

3. Naptime preparations shall have been completed and all children above 12 months of age shall be resting or sleeping, while all children 12 months of age or below shall be sleeping.

(e) The following staff/child ratios shall apply for centers serving children, 50 percent or more of whom have special needs, as a result of a cognitive, socio-emotional or physical handicap or disorder:

Age	Staff/Child Ratio
Under 2½ years	1:3
2½ years of age and over (non-ambulatory)	1:3
2½ years of age and over (ambulatory)	1:5

(f) Centers serving children who are sick shall comply with the variation on staff/child ratios for sick children, as specified in N.J.A.C. 10:122-8.3(c).

(g) In computing the required number of staff, the center shall apply the applicable staff/child ratios, as specified in (c) through (f) above, to the actual number of children in attendance at the center. The total number of staff members required for a center shall be the sum total of staff members required per room or area within a large room that has been divided by partitions, furniture or other barrier. The number of staff members per room or area within a large divided room shall be computed by dividing the number of children in attendance per room or area within a large divided room at any given time by the staff/child ratio required for the age of the children served. When this resulting figure is any fraction above a whole number, an additional staff member shall be required.

(h) When children of mixed ages requiring different staff/child ratios are in one room or area within a large divided room, the center shall compute the staff/child ratios applicable for each group separately to the nearest tenth decimal. If the resulting cumulative figure for all age groups is any fraction above a whole number, an additional staff member shall be required.

(i) For purposes of determining whether a required staff/child ratio is met, only those staff members who are involved in the direct care and supervision of children shall be counted.

(j) Staff members who are under 18 years of age shall be directly supervised by and visible to a staff member who is 18 years of age or older.

(k) For early childhood programs, the following shall apply:

1. A minimum of two staff members, one of whom shall be at least 18 years of age, shall be at the center and involved in the care of children when:

i. At least six children are present, who are below six years of age; or

ii. Fewer than six children are present but applicable staff/child ratios, governing children below 18 months of age and/or children with special needs, require two staff members.

2. The following minimum ages of staff members shall apply for purposes of computing the staff/child ratio:

i. Only staff members who are at least 14 years of age shall be counted for the staff/child ratio; and

ii. Staff members below 16 years of age shall only be utilized when school is not in session, or, if school is in session, only if they are participating in a school/work program.

(l) For school-age child care programs, the following shall apply:

1. A minimum of two staff members, one of whom shall be at least 18 years of age, shall be at the center and involved in the care of children at all times, except as specified in (l)2 and 3 below.

2. A minimum of one staff member, who shall be at least 18 years of age, shall be at the center and involved in the care of children when all the provisions in (l)2i through iv below are met:

i. Children attend for no more than one and one half hours;

ii. No more than five children present are below six years of age;

iii. No more than 12 children are present; and

iv. An additional adult has agreed to be available and immediately accessible in an emergency.

3. A minimum of one staff member, who shall be at least 18 years of age, shall escort up to 12 children on any walk including walks to and from their school and the center.

4. Only staff members who are at least 16 years of age shall be counted for the staff/child ratio.

10:122-4.4 Staff responsibilities

(a) The sponsor shall:

1. Be responsible for hiring or appointing a director; and

2. Ensure that the director operates the center in compliance with all applicable provisions of this manual.

(b) The director shall be responsible for ensuring:

1. That the center complies with all applicable provisions of this manual;

2. The supervision of all staff members, including:

i. Daily unannounced visits by the director or his or her designee, on a random daily time schedule, to each group of children; and

ii. For centers with an audio or visual monitoring system, as specified in N.J.A.C. 10:122-5.3(c)1i, observation of such a system, on a random daily time schedule, by the director or his or her designee;

3. The development and implementation of policies and procedures for the day-to-day operation of the center, including:

i. Maintenance of staff attendance sheets indicating daily hours worked; and

ii. Maintenance of children's daily attendance sheets, including the daily time of arrival and departure;

4. The orientation of staff members to the operation of the center, including physical layout, job descriptions, and daily policies and procedures;

5. The training of staff members, as specified in N.J.A.C. 10:122-4.7;

6. The development and maintenance on file of administrative, staff and children's records; and

7. The establishment and maintenance of a staff member substitute system.

(c) When the director is absent from the center for any length of time, he or she shall designate a responsible person to assume and carry out all responsibilities of the director, as specified in (b) above.

(d) When the director or any head teacher or required group teacher or required program supervisor is away from the center for six or more weeks, the sponsor or director shall hire and/or designate a staff member(s) who possesses the applicable staff qualifications for the position, as specified in N.J.A.C. 10:122-4.5, to assume the applicable responsibilities of the position, as specified in this section.

(e) The director or his or her designee(s) shall be on the premises at all times when the center is operating.

(f) For early childhood programs, the following shall apply:

1. The head teacher(s) shall:

i. Ensure the development and implementation of the center's child development and activities program for children below six years of age;

ii. Ensure the appropriateness of program activities according to both the age and developmental level of the child, as specified in N.J.A.C. 10:122-6.1(a); and

iii. Be scheduled to work for at least 75 percent of the center's daily operating hours, or at least six hours a day, whichever is less.

2. The group teacher(s) shall:

i. Be responsible for supervising a specific group(s) of children;

ii. Assist the head teacher in implementing the center's child development and activities program;

iii. Assist the head teacher in ensuring that the program activities are appropriate to both the age and developmental level of the children served, as specified in N.J.A.C. 10:122-6.1(a); and

iv. When used in lieu of a head teacher for centers having a capacity of up to 30 children, as specified in N.J.A.C. 10:122-4.2(b)1, fulfill the responsibilities for head teacher, as specified in (f) above.

3. For centers using a consulting head teacher, the following shall apply:

i. The consulting head teacher shall make two on-site visits to the center per month, to conduct staff training, observe the center's program, and ensure that the provisions specified in (f)1i and ii above are met.

ii. The center shall maintain on file a written record of the date, purpose and nature of each visit by the consulting head teacher.

(g) For school-age child care programs, the following shall apply:

1. The program supervisor shall:

i. Ensure the development and implementation of the center's child development and activities program for school-age children;

ii. Ensure the appropriateness of program activities according to the age and developmental level of the child, as specified in N.J.A.C. 10:122-6.1(a); and

iii. Be scheduled to work for at least 75 percent of the school-age child care program's daily operating hours, including time spent at both the before-school and after-school programs, if the center provides both programs.

10:122-4.5 Staff qualifications

(a) The center shall maintain on file documentation of the applicable staff education and experience, as specified in (b) through (d) below.

(b) The director shall meet the following qualification requirements:

1. For early childhood programs licensed to serve more than 30 children, the director shall meet the qualification requirements specified in one of the six options set forth in the chart below for education and experience:

OPTIONS FOR MEETING THE DIRECTOR QUALIFICATIONS

Option	Educational Credentials	and	Experience Requirements
A	Master's Degree in: —early childhood education; or —child development/psychology; or —business administration; or —any other field related to young children or business.		(N/A)
B	Bachelor's Degree		One year of managerial or supervisory experience in a child care program, educational institution, business, or program or agency related to children.
C	Child Development Associate (CDA) or Group Teacher Approval		Two years of managerial or supervisory experience in a child care program, educational institution, business, or program or agency related to children.
D	Six college credits in: —early childhood education; or —child development		Three years of managerial or supervisory experience in a child care program, educational institution, business, or program or agency related to children.
E	Six college credits in business administration/ management		Three years of managerial or supervisory experience in a child care program, educational institution or business, of which one year shall be in a field related to children.
F	High School Diploma or General Education Development (GED) Diploma		Four years of managerial or supervisory experience in a child care program, educational institution or business, of which two years shall be in a field related to children.

2. For early childhood programs licensed to serve 30 or fewer children, and for school-age child care programs regardless of capacity, the director shall meet the following qualification requirements:

i. One of the six options specified in the chart in (b)1 above; or

ii. A high school diploma or GED diploma and:

(1) Two years of managerial or supervisory experience in business and/or recreation fields; or

(2) Two years of experience in a group program for children.

(c) For early childhood programs, the following shall apply:

1. For all centers, the head teacher or consulting head teacher shall meet the qualification requirements specified in one of the six options set forth in the chart below for education and experience:

OPTIONS FOR MEETING THE HEAD TEACHER QUALIFICATIONS

Option	Educational Credentials	and	College Credits and Experience
A	Master's Degree in Education		Six credits and one year of experience
B	Master's Degree in any field other than Education		Nine credits and one year of experience
C	Bachelor's Degree in Education, Psychology, Health Care, Nursing, or any other field related to Child Growth and Development		Six credits and two years of experience
D	Bachelor's Degree in any field other than those listed in Option C		Nine credits and three years of experience OR Six credits and four years of experience
E	Teaching Certification from Department of Education in Elementary Education, Nursery School or Teacher of the Handicapped		Six credits and two years of experience
F	Teaching Certification from Department of Education in a field other than those listed in Option E		Nine credits and three years of experience OR Six credits and four years of experience

i. The credits specified in the chart above shall be college credits in early childhood education and/or child development. These credits may be part of the bachelor's or master's degree or constitute additional credits beyond the degree(s).

ii. For conditional approval, the center shall maintain on file documentation of enrollment in courses leading to the credits specified in the chart above. This conditional approval shall be valid for a maximum of nine months, at which time the center shall obtain and maintain on file a transcript indicating completion of these credits.

iii. The years of experience specified in the chart above shall be full time experience in a group program for children under six years of age. This experience may include supervised practice teaching and/or student teaching.

2. For centers approved either by the American Montessori Society (AMS) as an affiliated center or by the American Montessori International (AMI-USA) as a recognized or associated center, the head teacher or consulting head teacher shall have:

i. One of the options specified in the chart in (c)1 above; or

ii. A Montessori Pre-Primary Credential (AMS) or a Montessori Diploma (AMI-USA) and two years of full time experience in a group program for children under six years of age;

3. For recreation-type centers sponsored by a county or municipal government recreation and/or park department or agency, the head teacher or consulting head teacher shall have:

i. One of the options specified in the chart in (c)1 above; or

ii. Certification as a Recreation Administrator or a Recreation Supervisor from the New Jersey Department of Community Affairs, Board of Recreation Examiners (BRE) and two years of recreation experience; or

iii. Certification as a Recreation Professional from the National Recreation and Park Association (NRPA) and two years of recreation experience.

4. The group teacher shall meet the following education requirements:

i. An associate's degree in early childhood education or child development; or

ii. Fifteen college credits, of which a minimum of six credits shall be in early childhood education or child development. The remaining credits shall be from the areas of education, psychology, health care, nursing or any other field related to child growth and development. For conditional approval, the center shall maintain on file documentation of the following:

(1) When the individual meets the experience requirement in (c)5i below, 12 college credits in the areas in (c)4ii above and documentation of enrollment in a course(s) leading to the remaining three credits. This conditional approval shall be valid for a maximum of nine months, at which time the center shall obtain and maintain on file documentation showing that the individual has acquired the three additional credits; or

(2) When the individual has three years of teaching experience in a group program for children under six years of age, six college credits in early childhood education or child development. This conditional approval shall be valid for a maximum of two years, at which time the center shall obtain and maintain on file, documentation showing that the individual has acquired the nine additional credits; or

iii. A Child Development Associate (CDA) credential; or

iv. For recreation-type centers sponsored by a county or municipal government recreation and/or park department or agency, certification as a Recreation Technician from the NRPA, or the educational requirements specified in (c)4i, ii or iii above;

5. The group teacher shall meet the following experience requirements:

i. One year of teaching experience in a group program for children under six years of age, which may include supervised practice teaching and/or student teaching, for those group teachers who meet the requirements specified in (c)4i, ii or iii above; or

ii. For centers meeting the requirements in (a)4iv above, one year of recreation experience may be substituted for the experience specified in (a)5i above.

(d) For school-age child care programs, the following shall apply:

REQUIREMENTS FOR PROGRAM SUPERVISOR QUALIFICATIONS

Requirement	Licensed Capacity	Educational Credentials	and	Training and Experience
A	6-15	High School Diploma or General Education Development (GED) Diploma		6 hours (in child care) 2 years
B	16-30	High School Diploma or General Education Development (GED) Diploma		6 hours (in child care) 3 years
		-OR-		
		Certificate as a Recreation Technician from the National Recreation and Park Association (NRPA)		6 hours (in child care) 1 year
		-OR-		
		Child Development Associate (CDA) Certificate; Group Teacher Approval; or 15 college credits in child development, education, recreation, psychology, health care, nursing or any other field related to child growth and development		6 hours (in child care) 1 year
		-OR		
		15 college credits in areas not related to children		6 hours (in child care) 2 years
C	31 or more	High School Diploma or General Education Development (GED) Diploma		6 hours (in child care) 4 years and 3 hours (in child program management)
		-OR-		
		Certificate as a Recreation Technician from the National Recreation and Park Association (NRPA)		6 hours (in child care) 2 years and 3 hours (in child program management)
		-OR-		

Child Development Associate (CDA) Certificate; Group Teacher Approval; or 15 college credits in child development, education, recreation, psychology, health care, nursing or any other field related to child growth and development	6 hours (in child care) and 3 hours (in child program management) 2 years
-OR-	
15 college credits in areas not related to children	6 hours (in child care) and 3 hours (in child program management) 3 years
-OR-	
Associates Degree in child related field	6 hours (in child care) and 3 hours (in child program management) 2 years
-OR-	
Associates Degree in an unrelated field	6 hours (in child care) and 3 hours (in child program management) 2 years
-OR-	
Bureau of Licensing Head Teacher Approval	
-OR-	
Bachelor's Degree in a child related field	3 hours (in child program management) 1 year
-OR-	
Certificate as a Recreation Administrator, Recreation Supervisor or Recreation Professional	3 hours (in child program management) 1 year
-OR-	
Bachelor's Degree in an unrelated field	6 hours (in child care) and 3 hours (in child program management) 1 year

1. The training specified in the chart above shall:

i. Be clock hours of training;

ii. Be completed within nine months of Bureau of Licensing approval as program supervisor;

ii. Be in areas related to the ages of the children in care; and

iv. Meet the requirements specified in (d)2 and 3 below.

2. Child care training shall include at least two of the following:

i. Child growth and development;

ii. Positive guidance and discipline;

iii. Nutrition and good eating habits;

iv. Family involvement and communication with families;

v. Program planning and development;

vi. Creating a classroom environment;

vii. Health and safety procedures including recognition of illness and disease and training in basic infection control techniques; and

viii. Physical education or recreational activities for children.

3. Program management training shall include at least two of the following:

i. Program activity planning and development;

ii. Family involvement and communication with families;

iii. Availability of community services; and

iv. Personnel responsibilities and procedures.

4. The experience specified in the chart above shall be obtained in a group program for school-age children.

10:122-4.6 Grouping of children

(a) A group shall consist of the number of children:

1. Occupying an individual room or occupying a specific area within a large room. The area shall be defined by a visible barrier, partition or any other room divider or separation having a height above the eye level of the children who will use that area; or

2. Engaged together in a particular activity at any given time, regardless of whether the room or area within a large room is divided or partitioned.

(b) For early childhood programs, the following shall apply:

1. Each group shall be limited to a maximum of 20 children except during meals, naptime, outdoor activities, specially scheduled events (for example, parties, community speakers, films, etc.), and daily information sharing sessions (for example, "circle time"), which shall not exceed 15 minutes in duration.

2. For children under 2½ years of age, in addition to (a) and (b)1 above, a particular staff member shall be assigned to a specific group of children, in accordance with applicable staff/child ratios, as specified in N.J.A.C. 10:122-4.3.

(c) For school-age child care programs, the following shall apply:

1. Each group shall be limited to a maximum of 30 children except during meals, outdoor activities and specially scheduled events.

10:122-4.7 Staff training and development

(a) The director shall ensure that all staff members are trained in the following:

1. Understanding center operations, policies and procedures, as specified in N.J.A.C. 10:122-4.4(b)3;

2. Implementing the center's statement of policy on the disciplining of children, as specified in N.J.A.C. 10:122-6.6;

3. Recognizing and reporting child abuse/neglect, as specified in N.J.A.C. 10:122-4.8;

4. Supervising all children, as specified in N.J.A.C. 10:122-4.3(a);

5. Implementing health practices, as specified in N.J.A.C. 10:122-7.1 through 7.11;

6. Evacuating the center, as specified in N.J.A.C. 10:122-5.2(k)1;

7. Using the fire extinguisher and fire alarms, as specified in N.J.A.C. 10:122-5.2(o);

8. Implementing the center's release policy, as specified in N.J.A.C. 10:122-6.5; and

9. Planning for and providing age appropriate activities, as specified in N.J.A.C. 10:122-6.1.

10:122-4.8 Special requirements to prevent child abuse and/or neglect

(a) The sponsor, director or any staff member shall verbally notify the Division's Office of Child Abuse Control or District Office immediately whenever there is reasonable cause to believe that a child has been subjected to abuse and/or neglect by a staff member(s), or any other adult, pursuant to the Child Abuse and Neglect Law (see N.J.S.A. 9:6-8.9, 8.10, 8.13 and 8.14).

(b) For centers serving children under the Division's supervision, the sponsor, director or any staff member shall report any suspected abuse or neglect of the child by his or her parent(s) or other family members to the Division caseworker assigned to the family.

(c) In addition to the reporting requirements specified in (a) above, the sponsor, director or any staff member shall advise the parent(s) of the occurrence of any unusual incident(s) that occurred at the center and that might indicate possible abuse and/or neglect involving the child. Such notification shall be made on the same day on which the incident occurred. Such incidents may include, but are not limited to, unusual sexual activity; violent or destructive behavior; withdrawal or passivity; or significant change(s) in the child's personality, behavior or habits. The center shall maintain on file a record of such incidents and documentation that parents have been informed of them.

(d) The Division, during the course of investigating an allegation of child abuse and/or neglect, may determine that corrective action is necessary to protect the children whenever:

1. The sponsor, director or staff member has been found by the Division's Institutional Abuse Investigation Unit (IAIU) to pose a risk of harm to children; and/or

2. The sponsor, director or staff member has committed an act of child abuse and/or neglect, as substantiated by the IAIU; and/or

3. The sponsor, director or staff member has been convicted of such acts.

(e) Whenever the Division makes a determination that corrective action is necessary to protect the children, the sponsor shall carry out the Division's recommendation for corrective action. Such corrective action may include, but not be limited to:

1. Removal or suspension of the affected sponsor, director or staff member(s) from the center or reassignment to other duties that do not involve contact with the children; or

2. When the sponsor, director or staff member resides at the facility where the center is located, removal of the affected employee from the premises for a period of time extending from one hour prior to the arrival of the children until one hour after the children have left.

(f) Such suspension, removal or reassignment, as specified in (e)1 and 2 above, shall remain in effect until the results of the Division's investigation have been determined, and a final decision in the matter has been rendered by the Bureau.

(g) Substantiation of the child abuse and/or neglect allegation by the Division's IAIU shall not, in itself, automatically result in the termination of the accused sponsor, director or staff member(s) from his or her position in the center, but shall constitute grounds for possible termination if the person's continued employment at the center would place the children at risk. Such determination shall be made by the Bureau after considering information provided by the sponsor, the affected staff member(s), the IAIU and law enforcement authorities, as applicable and available.

SUBCHAPTER 5. PHYSICAL FACILITY REQUIREMENTS

10:122-5.1 State, county and municipal government physical facility requirements

(a) A person seeking a license or a Certificate of Life/Safety Approval to operate a center shall comply with all applicable provisions of the New Jersey Uniform Construction Code, as specified in N.J.A.C. 5:23 and hereinafter referred to as the NJUCC.

1. For newly constructed buildings, for existing buildings whose construction code use group classification would change from that which it had been, or for existing buildings that require major alteration or renovation, the center shall obtain a Certificate of Occupancy (CO) issued by the municipality in which it is located, reflecting the center's compliance with the provisions of the NJUCC, and submit a copy of the CO to the Bureau, for one of the following use group classifications:

i. E (Educational) for buildings accommodating children 2½ years of age and/or older and having a total occupancy of 50 or more children;

ii. B (Business) for buildings accommodating children 2½ years of age and/or older having a total occupancy of more than five and fewer than 50 children;

iii. I-2 (Institutional) for buildings accommodating six or more children less than 2½ years of age; or

iv. A-3 or A-4 (Assembly) or one of the use group classifications specified in (a)1i, ii, or iii above for buildings accommodating school-age children only.

2. Plan reviews for centers to be located in newly constructed buildings shall be submitted as follows:

i. In addition to submitting preliminary and final architectural drawings to the local construction official, a sponsor that plans to construct a new or renovate an existing building for use as a center shall submit preliminary and/or final architectural drawings to the Bureau for review and approval prior to beginning construction.

ii. The sponsor shall submit to the Bureau revised final architectural drawings containing all Bureau-required items listed in the plan review, if any, and secure final approval from the Bureau prior to beginning construction.

3. For buildings constructed after the adoption of the NJUCC (1977), whose construction code use group classification is already E, B, I-2, A-3 or A-4 and that have not had major alterations or renovations since receipt of the CO, the center shall obtain the CO issued by the municipality in which it is located at the time the building was originally constructed or approved for use in the NJUCC's E, B, I-2, A-3 or A-4 use group classification. The center shall submit a copy of the building's CO to the Bureau.

4. For existing buildings whose use prior to the adoption of the NJUCC (before 1977) was and continues to be for a center and that have not had major alterations or renovations, the center shall obtain a Certificate of Continued Occupancy (CCO), or a letter to this effect, issued by the municipality in which it is located, reflecting the building's compliance with provisions of the municipality's construction code requirements that were in effect at the time it was originally constructed or converted for use as a center. The center shall submit a copy of the building's CCO to the Bureau.

5. For school-age child care programs located in buildings constructed prior to January 1977 that do not have a valid CO or CCO, the center shall obtain a valid fire safety inspection certificate issued by the municipality in which it is located, based on a fire inspection conducted within the preceding 12 months, and submit a copy of the certificate to the Bureau.

6. The center shall obtain a new CO issued by the local municipality in which the center is located, and submit a copy to the Bureau, reflecting the building's compliance with provisions of the applicable NJUCC use group classification, whenever the center:

i. Changes the building's use group classification to one other than the one prescribed on its original CO;

ii. Makes a major alteration or renovation, as defined by the NJUCC, of the building or premises in which the center is located;

iii. Increases the floor area or the number of stories to the building or premises in which the center is located; or

iv. Relocates to another site.

7. Whenever a municipality grants to a center a written variation(s) from any of the requirements of the NJUCC, the Bureau may accept such variation(s) as meeting the applicable requirement(s) of this manual.

i. If the Bureau does not accept the variation, the non-acceptance shall be based on the best interests of the children in the center, and shall include consideration for their health and safety.

ii. If the center disagrees with the Bureau, the center may seek a hearing in accordance with N.J.A.C. 10:122-2.5(a) and the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1, as implemented by the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

(b) An applicant seeking a license or a Certificate of Life/Safety Approval to operate a center shall comply with all applicable provisions of the New Jersey Uniform Fire Code, as specified in N.J.A.C. 5:18, 5:18A and 5:18B and hereinafter referred to as the NJUFC. The center shall obtain the building's fire safety inspection certificate issued by the municipality in which it is located, based on a fire inspection conducted within the preceding 12 months, reflecting the center's compliance with all applicable provisions of the NJUFC. The center shall maintain on file the building's fire safety inspection certificate.

(c) The center shall comply with all applicable provisions of the State Sanitary Code, as specified in N.J.A.C. 8:24. The center shall obtain a certificate or statement of satisfactory health approval issued by the applicable municipal, county or State health agency, based on a health inspection conducted within the preceding 12 months, certifying that the center complies with all applicable provisions of local, county and State health codes and poses no health hazard to the children served. The center shall maintain on file the certificate or statement of satisfactory health approval.

(d) An applicant seeking the renewal of a license or of a Certificate of Life/Safety Approval to continue operating a center shall obtain and maintain on file a fire safety inspection certificate for the building based on a fire inspection conducted within the preceding 12 months, and a certificate or statement of satisfactory health approval for the center based on a health inspection conducted within the preceding 12 months.

(e) A center that qualifies for a Certificate of Life/Safety Approval shall meet the provisions of N.J.A.C. 10:122-2 and 5.

(f) A center that plans to locate or is already located in a hospital or other health care facility, as defined in the Health Care Facilities Planning Act, N.J.S.A. 26:2H-1 et seq., shall obtain a letter from the Department of Health indicating that department's approval. The center shall submit a copy of the approval letter to the Bureau.

10:122-5.2 Physical plant requirements

(a) Indoor maintenance and sanitation requirements are as follows:

1. The center shall be free of moisture resulting from water leaks or seepage.

2. Floors, carpeting, walls, window coverings, ceilings, and other surfaces shall be kept clean and in good repair.

3. Stairways shall be free of tripping hazards, such as toys, boxes, loose steps, uneven treads, torn carpeting, raised strips, or uneven risers.

4. Carpeting shall be securely fastened to the floor.

5. Garbage receptacles shall be:

i. Made of durable, leakproof and nonabsorbent materials;

ii. Covered in a secure manner;

iii. Emptied to the outdoor garbage receptacle when filled; and

iv. Maintained in a sanitary manner.

6. Food waste receptacles shall be lined and maintained in clean and sanitary condition.

7. The center shall be free of rodent or insect infestation and shall take immediate action to remove any infestation that may occur. The center shall maintain on file a record documenting the use of extermination services.

8. Toilets, wash basins, kitchen sinks, and other plumbing shall be maintained in good operating and sanitary condition.

9. All corrosive agents, insecticides, bleaches, detergents, polishes, any products under pressure in an aerosol spray can, and any toxic substance shall be stored in a locked cabinet or in an enclosure located in an area not accessible to the children.

10. All windows and other glass surfaces that are not made of safety glass and that are located within 36 inches above the floor shall have protective guards.

11. Ventilation outlets shall be clean and free from obstructions, and filters shall be replaced when saturated.

12. Walls shall be painted or otherwise covered whenever there is evidence of:

i. Excessive peeling or chipped paint; or

ii. Heavily soiled conditions.

13. All shelving shall be secured and not overloaded.

(b) Outdoor maintenance and sanitation requirements are as follows:

1. The building, land, walkways, and outdoor play area shall be free from hazards to the health, safety or well-being of the children.

2. The outdoor play area shall be graded or provided with drains to dispose of surface water.

3. The building structure shall be maintained to prevent:

i. Water from entering;

ii. Excessive drafts or heat loss; and

iii. Infestation from rodents and insects.

4. The railings of balconies, landings, porches, or steps shall be maintained in safe condition.

5. Garbage receptacles shall be:

i. Made of durable, leakproof and nonabsorbent materials;

ii. Covered in a secure manner and located in an outdoor area; and

iii. Maintained in a sanitary manner.

6. Centers that provide outdoor space shall maintain in proper condition all fencing or other natural or man-made barriers or enclosures.

(c) Lighting requirements are as follows:

1. All fluorescent tubes and incandescent light bulbs shall have protective covers or shields.

2. During program activities, at least 20 foot-candles of natural or artificial light shall be provided in all rooms used by the children. This illumination shall be measured three feet above the floor at the farthest point from the light source.

3. Parking areas, pedestrian walkways, or other exterior portions of the premises subject to use by center occupants at night shall be illuminated to provide safe entrance to and egress from the center.

(d) Heating requirements are as follows:

1. A minimum temperature of 68 degrees Fahrenheit shall be maintained in all rooms used by the children.

2. Steam and hot water pipes, radiators, and electrical space heaters shall be protected by screens, guards, insulation or any other suitable, non-combustible protective device.

3. The center shall not use portable liquid fuel-burning or wood-burning heating appliances.

(e) All floor and window fans that are accessible to the children shall have a grille, screen, mesh or other protective covering.

(f) Toilet facility requirements are as follows:

1. For centers that began operating or changed their use group on or after September 21, 1987, the number of toilets and sinks required shall be determined in accordance with applicable provisions of the Plumbing Subcode of the NJUCC, as specified in N.J.S.A. 52:27D-119 et seq.

2. A supply of soap, toilet paper, and individual hand towels or disposable paper towels shall be provided.

3. Mirrors, dispensers, and other equipment shall be fastened securely.

4. Platforms shall be available as appropriate for use by the children when adult size toilets, and/or sinks, and/or urinals are used by the children.

(g) A center utilizing a kitchen facility and/or food preparation area shall ensure that the cooking equipment and kitchen facility are kept in clean and sanitary condition and are operated in compliance with applicable provisions of the State Sanitary Code, as specified in N.J.A.C. 8:24.

(h) Lead paint precautions are as follows:

1. The center shall not use lead paint on and shall remove lead paint from any interior or exterior surfaces of a building used as a center, or on any furniture, toys, or other equipment used therein, in accordance with provisions of the State Lead Paint Law, pursuant to N.J.S.A. 24:14A-1 et seq., and with the provisions of the State Sanitary Code, as specified in N.J.A.C. 8:51-7.

2. When lead paint is found in areas of a center not specified in N.J.A.C. 8:51-7, the Bureau shall determine whether the lead paint is hazardous to the health, safety and well-being of the children served and, if considered to be hazardous, the center shall remove the lead paint hazard.

(i) Asbestos precautions are as follows:

1. Coatings containing asbestos shall not be sprayed on any interior or exterior surfaces of a building used as a center, or on any equipment used therein, in accordance with rules of the State Department of Environmental Protection, as specified in N.J.A.C. 7:27-17.2 and with applicable provisions of the Asbestos Hazard Abatement Subcode of the NJUCC, as specified in N.J.A.C. 5:23-8.

2. If the New Jersey Department of Health determines the presence of sprayed-on asbestos-containing materials, and concludes that corrective action must be taken to minimize exposure potential, the sponsor shall follow the recommendation of the State Health Department for enclosure, removal or other appropriate action to remove the threat or risk of asbestos contamination, as specified in N.J.A.C. 5:23-8.

(j) Wading and swimming pool requirements are as follows:

1. Pools that are at least 24 inches in depth shall be defined as swimming pools and subject to the requirements specified in (j)3 below. Pools that are less than 24 inches in depth shall be defined as wading pools.

2. For wading pools that do not have water filtration systems, the center shall change the water after each use by a group of children.

3. The center shall ensure that any swimming pool or natural bathing place used by the children complies with applicable provisions of the Public Recreational Bathing Rules, as specified in N.J.A.C. 8:26, and with applicable provisions of the Building Subcode and Barrier-free Subcode of the NJUCC, as specified in N.J.A.C. 5:23.

4. The center shall ensure that the children using swimming pools or natural bathing facilities are supervised in accordance with applicable provisions of the New Jersey Youth Camp Safety Act rules, as specified in N.J.A.C. 8:25.

5. If a child defecates in the swimming pool, all solid wastes shall be removed and the pool shall be super-chlorinated and not used until the chlorine level returns to levels identified as acceptable in the Public Recreational Bathing Rules, N.J.A.C. 8:26.

(k) Emergency evacuation instruction requirements are as follows:

1. The center shall prepare written emergency evacuation instructions delineating:

i. The location of the first aid kit and any additonal first aid supplies;

ii. The name, address and telephone number of the physician retained by the center or of the health facility to be used in emergencies;

iii. The procedure for obtaining emergency transportation;

iv. The hospital and/or clinic to which injured or ill children will be taken;

v. The telephone numbers of the local police and fire departments and ambulance service;

vi. The location of written authorization from parent(s) for emergency medical care for each child;

vii. A diagram showing how the center is to be evacuated in case of emergency; and

viii. The location of fire alarms and fire extinguishers.

2. The emergency evacuation instructions shall be posted in a prominent location on every floor within the center.

(l) Supplemental evacuation requirements are as follows:

1. Cribs, beds, playpens, cots or mats used for rest or sleep shall be placed at least one foot apart and shall be arranged so as to provide access to a three-foot-wide aisle that leads to an unobstructed exit.

2. To assure the safe and timely evacuation of the children from the center during a fire or other emergency, centers required to secure a Certificate of Life/Safety Approval shall meet the minimum staff/child ratio requirements, as specified in N.J.A.C. 10:122-4.3(c).

(m) Fire prevention requirements are as follows:

1. The center shall conduct fire drills at least once a month.

2. Centers serving sick children shall comply with the fire drill variation provisions specified in N.J.A.C. 10:122-8.4(e).

3. The center shall maintain on file a record of each fire drill, which record shall include:

i. The date and time of day of the drill;

ii. The weather condition at the time of evacuation;

iii. The number of participating children and staff members; and

iv. The total amount of time taken to evacuate the center.

4. All fire extinguishers shall be serviced and tagged at least once a year and recharged, if necessary.

(n) First aid requirements are as follows:

1. A staff member who has current certified basic knowledge of first aid principles and cardiopulmonary resuscitation (CPR), as defined by a recognized health organization (such as the American Red Cross), should be in the center during periods of operation.

2. The following equipment shall be placed in a location that is convenient and accessible to staff members:

i. A standard first aid kit, which is fully re-stocked within 24 hours of use; and

ii. The American Red Cross First Aid Manual or its equivalent.

(o) All staff members shall be instructed annually in the use of fire extinguishers, alarms and the emergency evacuation information specified in (k)1 above. The center shall maintain on file a record of the training sessions.

(p) Play equipment, materials, and furniture for indoor and outdoor use shall be of sturdy and safe construction, non-toxic and free of hazards.

(q) Space and room requirements are as follows:

1. All space and rooms within the center to be used by children shall be inspected and approved by the Bureau prior to their use. In making its determination, the Bureau shall consider whether the space is too far removed, remote or isolated from other areas of the center to be used by children.

i. For those rooms or areas that are too far removed, remote or isolated from other centrally located rooms or areas of the center, the Bureau may require the use of additional staff members, above those required for staff/child ratios, before granting approval.

ii. Rooms or areas of the center that are not Bureau-approved for use by children shall be made inaccessible to children.

2. At no time shall a center allow more children in attendance than the number specified on its license or Certificate of Life/Safety Approval.

3. Indoor space requirements for play rooms and/or sleep rooms are as follows:

i. There shall be a minimum of 30 square feet of usable activity indoor floor space for each child in centers that:

(1) Began operating prior to July 1, 1989; or

(2) Began operating on or after July 1, 1989 and serve fewer than 16 children.

ii. There shall be a minimum of 35 square feet of usable activity indoor floor space for each child in centers that began operating on or after July 1, 1989 and serve 16 or more children.

iii. The minimum square footage of usable activity indoor floor space shall be determined by excluding the space used in or by hallways, toilet facilities, offices, storage rooms, staff rooms, furnace rooms, kitchen areas, lockers, closets, and other stationary equipment or areas that children do not use for sleep or play.

iv. Centers serving sick children shall comply with the variation provisions on determining net indoor floor space per child, as specified in N.J.A.C. 10:122-8.4(a).

v. The center shall identify all rooms of the center that have been approved by the Bureau. This identification shall consist of numbers, letters, names or any other means of identification and shall be located either inside or directly outside each room.

4. Separate room or area requirements for children who become ill are as follows:

i. There shall be a room, section of a room, or a separate area in the center to which children who are exhibiting those illnesses, symptoms of illness, and diseases specified in N.J.A.C. 10:122-7.1(c) shall be taken and where they shall be cared for until they can return home, be suitably cared for elsewhere, or be diagnosed as posing no health risk to themselves or others.

ii. The separate room, section or area shall be furnished with sleeping equipment and sheets, blankets or other coverings.

iii. Centers serving only sick children shall comply with the variation provision for separating ill children, as specified in N.J.A.C. 10:122-8.4(b) and (c).

(r) The center shall take any steps required by the Bureau to correct conditions in the building or center that may endanger the health, safety and well-being of the children served.

(s) For early childhood programs, the following shall apply:

1. All electrical outlets that are accessible to the children shall have protective covers.

2. All lally columns in areas used by the children shall have protective padding placed around them from the floor to a height of at least 48 inches.

3. Crawl spaces, attic spaces, and all doors and windows used for natural ventilation shall be provided with insect screening.

4. A supply of hot tap water not exceeding 110 degrees Fahrenheit and cold running water shall be provided.

5. Toilet facility requirements are as follows:

i. For centers in operation prior to September 21, 1987 that serve children ages 18 months to six years, the minimum number of toilets and sinks required in the center shall be determined in accordance with the following table:

Number of Children	Number of Toilets	Number of Sinks
6-15	1	1
16-35	2	2
36-60	3	3
61-80	4	4
81-100	5	5
101-125	6	6
126-150	7	7
151-175	8	8
176-200	9	9
201-225	10	10
226-250	11	11
251-275	12	12
276-300	13	13
301-325	14	14
326-350	15	15
351-375	16	16
376-400	17	17
401-425	18	18
426-450	19	19

ii. For centers specified in (s)5i above, urinals may be counted in determining the number of toilets the center shall have, provided that:

(1) At least two toilets are available at the center; and

(2) Two urinals are counted as one toilet towards determining the maximum occupancy of the center.

iii. For centers in operation prior to September 21, 1987 that serve children below 18 months of age:

(1) In centers serving 15 or fewer children, there shall be at least one toilet and one sink.

(2) In centers serving more than 15 children, there shall be at least two toilets and two sinks.

iv. For centers in operation prior to September 21, 1987 that serve a mix of children ranging from birth through five years of age, the center shall either:

(1) Meet the toilet and sink requirements specified in (s)5i through ii above, based on the total number of children being served at the center, provided that all toilets and sinks are utilized by children of all ages; or

(2) Determine the number of children above and below 18 months of age and meet the toilet and sink requirements for the number of children being served in each age category, as specified in (s)5i through ii above.

v. Toilet facilities and sinks shall be located no more than one floor above or below the floor level(s) used by the children in centers that:

(1) Began operating prior to July 1, 1989; or

(2) Began operating on or after July 1, 1989 and serve fewer than 16 children.

vi. At least one toilet facility and sink shall be located on each floor level(s) used by children in centers that began operating on or after July 1, 1989 and serve 16 or more children.

6. Kitchen facility requirements are as follows:

i. The kitchen facility and/or food preparation area shall be separated from other areas of the center by a door, gate, screen or other barrier to prevent accidental access by children.

ii. The kitchen may be used for children's program cooking activities only when it is not being used for preparation of meals for consumption by enrolled children.

7. Outdoor space requirements for children over the age of 10 months are as follows:

i. For children in attendance for three or more consecutive hours, the center shall provide a minimum of 150 square feet of net outdoor space. When more than five children are using such a space at one time, there shall be 30 square feet of net outdoor space for each additional child in addition to the required minimum of 150 square feet.

ii. The outdoor area shall be adjacent to, within close proximity or in the same neighborhood of the center and available for use by the children.

iii. Outdoor areas located near or adjacent to hazardous areas determined by the Bureau to be unsafe (including, but not limited to, streets, roads, driveways, parking lots, railroad tracks, swimming pools, rivers, streams, steep grades, cliffs, open pits, high voltage boosters or propane gas tanks) shall be fenced or otherwise protected by a natural or man-made barrier or enclosure.

iv. If the center can demonstrate to the satisfaction of the Bureau that it cannot meet the outdoor space requirement, the center shall provide, in addition to space for play rooms, a minimum of 150 square feet of net indoor floor space. When more than five children are using such space at one time, there shall be 30 square feet of net indoor floor space for each additional child in addition to the minimum of 150 square feet. The indoor floor space may be either on the site of the center or at another nearby indoor facility, such as a gymnasium, exercise room or other recreational facility.

v. Centers serving only sick children shall comply with the variation provisions for outdoor space, as specified in N.J.A.C. 10:122-8.4(f)1.

8. All balconies, rooftops, verandas and/or all floor levels used by children that are above the first floor and subject the children to an open drop or atrium shall be protected by barriers consisting of safety glass, plexiglass or any other materials approved by the Bureau. Such barriers shall extend at least five feet above the floor level.

(t) For school-age child care programs, the following shall apply:

1. All lally columns in areas used by the children shall have protective padding around them from the floor to a height of at least 72 inches.

2. For centers that serve food, crawl spaces, attic spaces, and all doors and windows used for natural ventilation shall be provided with insect screening.

3. A supply of hot tap water not exceeding 120 degrees Fahrenheit and cold running water shall be provided.

4. Toilet facility requirements are as follows:

i. Children shall be afforded privacy, appropriate to their age and development, when toileting.

ii. For centers that began operating prior to September 21, 1987, the number of toilets and sinks required shall meet the specifications prescribed by the provisions of the Plumbing Subcode of the NJUCC for the E use group at the time the center began operating.

iii. Toilet facilities and sinks shall be located no more than one floor above or below the floor levels used by the children.

5. Indoor space requirements are as follows:

i. In centers specified in (q)3i above, there shall be an average of 30 square feet of usable activity indoor floor space for each child.

ii. In centers specified in (q)3ii above, there shall be an average of 35 square feet of usable activity indoor floor space for each child.

10:122-5.3 Special physical facility and monitoring requirements to prevent child abuse and/or neglect

(a) At least five foot-candles of natural or artifical light shall be provided in all rooms used by children during naptime. The illumination shall be measured three feet above the floor at the farthest point from the light source.

(b) Doors in all interior rooms designated for use by children shall remain unlocked.

(c) For rooms and/or areas used by children, except as specified in (e) below, the following monitoring requirements shall apply:

1. The center shall equip every room or area designated for use by children, except for kitchen and toilet facilities, with one of the following options in order to promote maximum visibility and/or audibility:

i. A centrally supervised audio or visual monitoring system;

ii. Uncovered and unobstructed glass panels and/or two-way mirrors that comprise at least 10 percent of the square footage of one interior wall, provided that such panels/mirrors are not in conflict with applicable provisions of the NJUCC and/or the NJUFC;

iii. Security mirror(s) in hallways that reflect actions in the room(s) used by children.

iv. At least one interior door leading to every room designated for use by children, which shall meet one of the following conditions, provided that such conditions are not in conflict with applicable provisions of the NJUCC and/or the NJUFC:

(1) Be left open;

(2) Have uncovered and unobstructed windows or cutouts;

(3) Be a dutch door variety, with the top half open; or

(4) Be removed; or

v. Any other Bureau-approved monitoring system or equipment that provides equivalent visibility and audibility.

(d) Toilet facility requirements are as follows:

1. For existing centers that have only one toilet facility, or for existing centers that have more than one toilet facility, but where all toilets have been counted in determining the maximum number of children who can be served per session, the center shall ensure that staff members and/or other adults who use the toilet facility for their own toileting needs do so only:

i. When children are not in it; and

ii. After the staff member and/or other adult has secured the door with a lock or latch that is located on the inside of the door at a height beyond the reach of the children.

(1) If a center documents to the satisfaction of the Bureau that it lacks the authority to meet the lock/latch provisions noted in (d)1ii above, the Bureau may approve an alternative means by which the center may comply with the privacy intent of this provision.

2. For existing centers that have an additional toilet facility that has not been counted in determining the maximum number of children who can be served per session and for centers to be located in newly constructed buildings, the center shall ensure that:

i. One toilet facility is reserved and designated for the exclusive use of staff members and/or other adults; and

ii. This designated toilet facility is identified by a sign located on the exterior of its door, indicating that this toilet facility is for the exclusive use of staff members and/or other adults.

(e) For early childhood programs, the following shall apply:

1. Centers that are to be located in newly constructed buildings that seek to serve 16 or more children shall equip every room designated for use by children, except for kitchen and toilet facilities, with either uncovered glass panels or two-way mirrors that comprise at least 10 percent of the square footage of at least one interior wall in order to promote maximum visibility in such rooms.

SUBCHAPTER 6. PROGRAM REQUIREMENTS

10:122-6.1 Activities

(a) The center shall develop and provide a variety of children's planned activities, geared to the age and developmental level of the children served, that:

1. Promote the development of language, thinking and problem-solving skills, curiosity, exploration, large and small muscles, social competence, self-esteem, and positive self-identity; and

2. Are relevant to the cultural background of the children and foster intercultural awareness.

(b) The staff member(s) specified in N.J.A.C. 10:122-4.4 who are responsible for developing and overseeing the implementation of the center's daily activities shall ensure that:

1. Time frames for each activity are geared to the age and developmental level of each child served and are flexible enough to accommodate spontaneous occurrences or children's suggestions and inquiries;

2. Children have opportunities to choose materials freely;

3. Children are presented with and encouraged to participate in a mixture of active and quiet experiences;

4. Both staff-directed and child-selected activities are provided; and

5. Children are:

i. Encouraged, but not required, to participate in every group activity; and

ii. Provided with the time and space within the area to be apart from the group and to participate in an alternate activity if they choose to do so.

(c) The center shall ensure that children riding bicycles wear a helmet, as specified in the Bicycle Helmet Law, N.J.S.A. 39:4-10.1.

(d) Centers serving sick children shall comply with the variation on developing and providing children's activities, as specified in N.J.A.C. 10:122-8.5(a).

(e) The staff member(s) specified in (b) above shall prepare and maintain on file a written outline of the center's daily activities, as specified in (a) through (d) above and (f) and (g) below.

(f) For early childhood programs, the following shall apply:

1. Outdoor experiences shall be provided as follows:

i. Children who are at the center for more than four consecutive hours shall be taken outdoors daily.

ii. Children who are at the center for four or fewer consecutive hours shall be taken outdoors at least once a week.

iii. A center may depart from the requirements specified in (f)1i and ii above during inclement weather or for another reason that affects the health, safety or well-being of the children or any individual child.

2. Centers serving children less than 18 months of age shall provide:

i. At least four of the following types of children's daily activities: sensory; language/dramatic play; manipulative; building; large muscle; music; or other comparable activities; and

ii. At least four types of supplies and/or equipment for each activity area chosen by the center, as listed below:

(1) Sensory activities: crib mobiles; teething toys; busy boxes; baby mirrors; rattles; melody chimes; squeeze toys; or other comparable supplies or equipment.

(2) Language/dramatic play activities: picture books; toy telephones; records; hand puppets; stuffed animals; soft washable dolls; photographs; or other comparable supplies or equipment.

(3) Manipulative activities: squeeze and grip toys; boxes; sorting and stacking toys; three and/or four piece wooden inlay puzzles; puzzle blocks; simple threading toys; mobile pull toys; balls; or other comparable supplies or equipment.

(4) Building activities: soft lightweight blocks; toy cars, trains and/or boats; figures of animals and people; stacking rings and/or cups; nesting toys; or other comparable supplies or equipment.

(5) Large muscle activities: low climbers; slides; riding/rocking toys; foam or soft plastic balls; gym mats; play tunnels; or other comparable supplies or equipment.

(6) Music activities: rhythm instruments; record player and records; toys equipped with musical tones; musical mobiles and/or busy boxes; drums, xylophones and/or pianos; or other comparable supplies or equipment.

iii. Staff members shall provide periodic activity or learning opportunities to stimulate the five senses of children who are awake and being cared for in cribs, playpens or other Bureau-approved sleeping equipment.

iv. Staff members shall carry non-ambulatory infants around the center periodically.

v. Staff members shall provide all children who are developmentally able with opportunities to leave their cribs, playpens or other Bureau-approved sleeping equipment to crawl, toddle, walk, and play.

3. Centers serving children 18 months of age and older shall provide:

i. At least five of the following types of children's daily activities: language; science and mathematics; manipulative; large muscle; building; art; music; drama; or other comparable activities; and

ii. At least five types of supplies and/or equipment for each daily activity chosen by the center, as listed below:

(1) Language activities: books; flannel board; upper and lower case letters; pictures for discussion; materials for recognition, identification and/or classification; poetry; puppets; audio-visual materials; show and tell items; or other comparable supplies or equipment.

(2) Science and math activities: plants and gardening equipment; aquarium with fish and/or other appropriate live animals; water table and supplies; sand table and supplies; cooking supplies; weather chart and/or thermometer; counting equipment; or other comparable supplies or equipment.

(3) Manipulative activities: puzzles; pegs and pegboards; lacing boards; table top building toys; stencils; dominoes; pounding bench; lotto games; or other comparable supplies or equipment.

(4) Large muscle activities: rocking boat; wheel toys; climbers; slides; balance beam; barrels and/or large cartons; parachute; balls and beanbags; outdoor play equipment; gym mats; or other comparable supplies or equipment.

(5) Building activities: unit blocks (minimum of four sizes); transportation toys; farm animals and/or play people; work bench and tools; table top building toys; building logs; or other comparable supplies or equipment.

(6) Art activities: crayons; tempera paint, large brushes and newsprint; finger paint and finger paint paper; construction paper in assorted colors; paste or glue; blunt scissors; collage materials; non-toxic felt tip markers; easels; clay or playdough; or other comparable supplies or equipment.

(7) Music activities: record player and records; piano and/or organ; guitar; rhythm sticks; drums; cymbals and bells; tape recorder; or other comparable supplies or equipment.

(8) Dramatic activities: toy dishes; ironing board; telephones; occupational props and/or uniforms; dress-up clothes; housekeeping area (stove, sink, refrigerator); cradle or doll bed; doll carriage and dolls; puppets; grocery store, post office or hospital; or other comparable supplies or equipment.

4. Centers that operate during evening hours shall ensure that the activity level for children is reduced in preparation for sleep and shall provide a selection of toys or other materials for quiet activities.

(g) For school-age child care programs, the following shall apply:

1. Centers shall plan and implement programs that include:

i. Activities that reflect the interests and skills of the children served;

ii. Opportunities for child involvement in activity planning;

iii. Opportunities for self-selected activities;

iv. Recreational opportunities, including a mixture of indoor/outdoor and large muscle activities; and

v. Daily schedules that include individual quiet times, structured and unstructured activities, and small-group and large-group activities.

10:122-6.2 Program equipment for children's daily activities

Centers shall provide a supply of age and developmentally appropriate program equipment including play equipment, child-size furniture and supplies that are sufficient to meet the daily activity needs of the children and the program.

10:122-6.3 Food and nutrition

(a) All centers shall comply with the following requirements:

1. Food served to children who are present during normal mealtime hours or required snack periods, as specified in (b) and (c) below, shall be provided either by the child's parent or by the center.

2. If the center chooses to provide food, the center shall ensure that all food served to children is prepared by either:

i. The center on-site or off-site; or

ii. A caterer who is licensed, registered, certified or otherwise approved, as appropriate, by the local, county or State Department of Health, as applicable.

3. If the center chooses to have parents provide food, the center shall have a supply of food at the center for any child whose parent forgets.

4. If the center provides food, the center shall ensure that the food is stored, prepared, and served in a sanitary manner.

5. Staff members shall advise parents of any repetitive feeding problems experienced by their child.

6. Staff members shall not force-feed or coerce a child to eat against his or her will.

7. A snack shall be served to all children who are under the center's care for at least three consecutive hours and for all children who are served on an after-school basis.

8. Drinking water shall be made available to all children.

9. Centers that provide meals shall ensure that:

i. For children on special diets (for example, due to health reasons, religious belief or parental request), an alternative choice of food is provided by either the center or the child's parent; and

ii. Individualized written diets and feeding schedules, if submitted to the center by the child's parent(s) or physician, are posted in a location that is accessible to staff members caring for the children, and are followed.

(b) For early childhood programs, the following shall apply:

1. Centers operating for more than three consecutive hours shall have a working refrigerator.

2. Food brought from outside the center for a child shall be inspected by a staff member for spoilage before it is served.

3. Feeding requirements for centers serving children less than 18 months of age are as follows:

i. The center shall develop mutually with each child's parent(s) and follow a written plan regarding the feeding schedule, specific formula, nutritional needs, and introduction of new food for each child;

ii. The written plan shall be:

(1) Maintained on file; and

(2) Made available to each staff member responsible for feeding each child;

iii. All food served to a child shall be appropriate to the child's developmental eating ability;

iv. Each child's bottle(s) shall be labeled with the child's name;

v. A child who is too young to use a feeding chair or other seating apparatus shall be held when fed;

vi. A child who, because of age or developmental readiness, no longer needs to be held for feeding shall be provided with an infant seat, high chair with safety strap, or other age-appropriate seating apparatus; and

vii. When a child is feeding, the bottle shall not be propped at any time.

4. Mealtime and snack requirements for centers serving children 18 months of age and above and those children younger than 18 months of age who are developmentally ready to eat regular meals and snacks are as follows:

i. The center shall serve breakfast for all children who have not eaten breakfast and are present from 7:00 A.M. to 9:00 A.M.;

ii. The center shall serve lunch for all children who have not eaten lunch and are:

(1) Present during 11:00 A.M. to 1:00 P.M.; and

(2) Under the center's care for at least five consecutive hours;

iii. The center shall serve dinner for all children who:

(1) Have not eaten dinner;

(2) Are present from 5:00 P.M. to 7:00 P.M.; and

(3) Are scheduled to remain after 7:00 P.M.;

iv. Centers that provide meals shall ensure that breakfast includes the following:

(1) Fruits or vegetables or full-strength fruit or vegetable juice; and

(2) Enriched whole grain bread, a bread product or cereal and/or a protein alternative;

v. Centers that provide meals shall ensure that lunch and dinner for each child include the following:

(1) Meat, poultry, fish or a protein alternative;

(2) Fruits or vegetables;

(3) Bread or bread products; and

(4) Milk, juice or water;

vi. Centers that provide meals shall ensure that the snack includes one full-strength juice, milk or fruit and one food supplement selected from the lunch and dinner choices specified in (b)4v above, except on special occasions, such as holidays and birthdays; and

vii. Milk is served at least once a day.

(c) For school-age child care programs, the following shall apply:

1. Centers that store perishable foods or medication shall have access to a refrigerator.

2. Centers that provide snacks should include one full-strength juice, milk or fruit and one food supplement selected from the food choices specified in (b)4v above.

3. On days when school is not in session, if applicable, the center shall serve meals as specified in (b)4 above.

10:122-6.4 Rest and sleep requirements for early childhood programs

(a) For centers serving children 12 months of age and younger, the following shall apply:

1. The center shall provide opportunities for daily rest and sleep for each child according to the child's individual physical needs.

2. The center shall provide each child with a crib, playpen or other Bureau-approved sleeping equipment that provides equivalent safety and comfort for use during rest and sleep.

i. Each crib or playpen shall be equipped with:

(1) A waterproof, snugly fitting mattress;

(2) A clean sheet or other covering and blanket;

(3) Top rails that are at least 19 inches above the mattress; and

(4) Slats that are not more than 2⅜ inches apart.

ii. Any locks or latches on the dropside of a crib shall be safe and secure from accidental release.

(b) For centers serving children over the age of 12 months and under the age of five years, the following shall apply:

1. The center shall provide opportunities for daily rest and/or sleep for each child who:

i. Attends the center for four or more consecutive hours; or

ii. Attends the center for fewer than four consecutive hours, but whose individual physical needs call for a rest period while the child is at the center.

2. An alternative quiet activity shall be provided for those children who have rested or slept for 30 minutes and do not appear to need additional rest or sleep.

3. Each child shall be provided with a crib, playpen, cot, mat or other Bureau-approved sleeping equipment for use during rest and sleep, which shall comply with the requirements specified in (a)2 above.

i. Each cot used for children between 13 and 18 months of age shall not exceed 14 inches above floor level.

ii. Each cot or mat used for rest and sleep shall be covered with a sheet, blanket or other covering. An additional covering shall be provided for use as a covering for each child.

iii. Each mat used for rest and sleep shall be:

(1) Placed on a surface that is warm, dry, clean and draft-free;

(2) Water-repellent;

(3) At least one inch thick; and

(4) Stored so that there is no contact with the sleeping surface of another mat, or disinfected after each use, as specified in N.J.A.C. 10:122-7.7(a)1.

(c) Centers serving children in attendance for three hours or less after 7:00 P.M. shall meet the sleeping requirements, as specified in (a) and (b)3 above.

(d) Centers serving children in attendance for more than three hours after 7:00 P.M. shall:

i. Establish bedtime schedules for each child in consultation with parent(s);

ii. Ensure that any Bureau-approved sleeping equipment, other than a bed or mat, has been fitted with a minimum one-inch thick water-repellent mat or mattress; and

iii. Ensure that each child is changed into sleeping garments.

(e) Sheets, blankets and other coverings shall be:

1. Changed when wet, soiled or damaged; and

2. Changed before use by another child.

(f) When cribs, playpens, cots, mats or other Bureau-approved sleeping equipment are stored with sheets, blankets or other coverings as single units, at least one item of each unit shall be labeled with child-identifying information.

(g) When sheets, blankets and other coverings are not stored with sleeping equipment, each of these items shall be:

1. Labeled for each child; and

2. Stored separately for each child.

(h) During rest and sleep periods, only one child shall occupy a crib, playpen, cot, mat or other Bureau-approved sleeping equipment at one time.

10:122-6.5 Policy on the release of children

(a) The center shall maintain on file a written policy on the release of children, which shall include:

1. The provision that each child may be released only to the child's custodial parent(s) or person(s) authorized by the custodial parent(s), as specified in N.J.A.C. 10:122-6.8(a)1ii and iii, to take the child from the center and to assume responsibility for the child in an emergency if the custodial parent(s) cannot be reached;

2. The provision that a child shall not be visited by or released to a non-custodial parent unless the custodial parent specifically authorizes the center to allow such visits or releases in writing. This written authorization, including the name, address and telephone number of the non-custodial parent(s), shall be maintained on file. If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, the center shall secure documentation to this effect and maintain a copy on file;

3. Written procedures to be followed by staff member(s) if the parent(s) or person(s) authorized by the parent(s), as specified in (a)1 above, fails to pick up a child at the time of the center's daily closing. The procedures shall require that:

i. The child is supervised at all times;

ii. Staff members attempt to contact the parent(s) or person(s) authorized by the parents; and

iii. An hour or more after closing time, and provided that other arrangements for releasing the child to his or her parent(s) or authorized person(s) have failed and the staff member(s) cannot continue to supervise the child at the center, the staff member shall call the Division's 24-hour Child Abuse Hotline to seek assistance in caring for the child until the parent(s) or person(s) authorized by the child's parent(s) is able to pick up the child; and

4. Written procedures to be followed by a staff member(s) if the parent(s) or person(s) authorized by the parent(s), as specified in (a)1 above, appear to be physically and/or emotionally impaired to the extent that, in the judgement of the director and/or staff member, the child would be placed at risk of harm if released to such an individual. The procedures shall require that:

i. The child shall not be released to such an impaired individual;

ii. Staff members attempt to contact the child's other parent or an alternative person(s) authorized by the parent(s); and

iii. If the center is unable to make alternative arrangements, as noted in (a)3ii above, a staff member shall call the Division's 24-hour Child Abuse Hotline to seek assistance in caring for the child.

(b) For school-age child care programs, the following shall apply:

1. No child shall be released from the program unsupervised except upon written instruction from the child's custodial parent.

10:122-6.6 Discipline

(a) The methods of guidance and discipline used shall:

1. Be positive;

2. Be consistent with the age and developmental needs of the children; and

3. Lead to the child's ability to maintain self control.

(b) Staff members shall not discipline children for failing to eat or sleep or for soiling themselves.

(c) Children may be removed from a group activity to another area, provided that the child so removed is either under the supervision of another staff member or continuously visible to a staff member.

(d) The center shall maintain on file a written policy on the disciplining of children by staff members. The policy shall:

1. Reflect the provisions specified in (a) through (c) above and include the acceptable actions that a staff member may take when disciplining a child (that is, discussion with the child, time-out, etc.);

2. Be distributed to every staff member; and

3. Be posted in a prominent location within the center.

(e) The center shall secure and maintain on file each staff member's signature, attesting to receipt of the policy on the disciplining of children by staff members.

(f) For school-age child care programs, the following shall apply:

1. The center shall permit children to participate in the development of the discipline rules and procedures; or

2. The center shall establish procedures to ensure that children are aware of the rules.

10:122-6.7 Special requirements to prevent child abuse and/or neglect and inappropriate staff behaviors toward children

(a) Staff members shall not use hitting, shaking or any other form of corporal punishment of children.

(b) Staff members shall not use abusive language, ridicule, harsh, humiliating or frightening treatment or any other form of emotional punishment of children.

(c) Staff members shall not engage in or inflict any form of child abuse and/or neglect.

(d) Staff members shall not withhold from children food, emotional responses, stimulation, or the opportunities for rest or sleep.

(e) Staff members shall not require a child to remain silent or inactive for an inappropriately long period of time for the child's age.

10:122-6.8 Parent and community participation

(a) Prior to the child's enrollment, the center shall:

1. Obtain a signed application, including:

i. The child's name, address, birth date, and date of enrollment;

ii. The name(s), home and work address(es), and home and work telephone number(s) of the custodial parent(s);

iii. The name(s), address(es), and telephone number of any person(s) authorized by the parent(s) to visit the child at the center and/or take the child from the center, as specified in N.J.A.C. 10:122-6.5(a)1;

iv. The name, address, and telephone number of the child's physician; and

v. Written authorization from the parent(s) for emergency medical treatment;

2. Inform parents about the center's days and hours of operation;

3. Discuss the individual child's habits, dietary and sleep needs, activities, behavior and development, if applicable;

4. Discuss the center's policies on releasing children, toilet training children when applicable, and dispensing medication;

5. Discuss and distribute the center's policy on the management of communicable disease, as specified in N.J.A.C. 10:122-7.11; and

6. Discuss and distribute an Information to Parents document, as specified in N.J.A.C. 10:122-3.6(a).

(b) The center shall allow the parent(s) of enrolled children to visit the center at any time during the center's hours of operation to observe its operation and program activities without requiring the parent(s) to secure prior approval.

(c) The center shall provide the parents of prospective enrollees the opportunity to visit the center to observe its operation and program activities, but may require that such visits are arranged in advance and at the convenience of the center director.

(d) Staff member(s) shall inform the parent(s) of enrolled children in advance of any field trip(s), outing(s), or special event(s) involving the transportation of children away from the center. Before taking a child on such a field trip, outing or special event, the center shall either:

1. Secure individual written consent slips signed by a parent for his or her child(ren) for each proposed field trip, outing or special event;

2. Post a notice of a proposed individual field trip, outing or special event in a place of prominence within the center, on which the parent must sign consent for his or her child to attend; or

3. Issue to every parent a written schedule of all field trips, outings or special events to be taken during any given time frame (that is, weekly, monthly, yearly). A parent must sign this schedule indicating his or her consent for any or all field trips, outings or special events listed.

(e) The center may utilize a blanket permission slip for taking children on walks only if:

1. Walks are within the center's neighborhood;

2. The center makes arrangements for the handling of visits or telephone calls from parents either by:

i. Having someone remain at the center; or

ii. Utilizing a telephone answering machine and posting a notice on the entrance door of the center to inform parents of the children's location;

3. The route of the walk involves no safety hazards; and

4. The walk involves no entrance into a facility unless the facility has been indicated on the blanket permission slip.

(f) The center shall maintain on file a record of signed blanket permission slips for walks and signed individual permission slips for field trips, outings or special events.

(g) The center should promote the involvement of representatives of the community to enhance the staff members' and the children's knowledge of community services, programs and resources.

(h) For early childhood programs, the following shall apply:

1. The center shall adopt at least one of the following options to ensure the participation of the parents of enrolled children in the activities and operations of the center:

i. A governing board responsible for approving, reviewing, and monitoring the center's policies, budget, staff recruitment and selection, physical environment, and program activities;

ii. An advisory committee that offers advice and counsel to the center on its policies, staff recruitment and selection, physical environment, and program activities; or

iii. An annual meeting to which all parents and staff members are invited for the purpose of sharing goals, recommendations, and concerns. The center shall maintain on file a record of this meeting.

2. Centers choosing the options specified in either (h)1i or ii above shall ensure that the board or committee includes the parents of enrolled children and representatives from the civic, business, educational and/or child care communities. The board or committee shall meet at least quarterly during the center's operating year and the center shall maintain on file a listing of current members of the board or committee and documentation indicating that the board or committee is functioning.

3. The center shall adopt, implement, and maintain on file a written policy providing for the direct involvement of parents of enrolled children in the center's operation and activities. This policy shall include the following:

i. An opportunity for parents to volunteer to help in the center's program;

ii. An annual open house to which parents are invited for the purpose of observing the program; and

iii. Parent/staff conferences held semi-annually and upon request of the parent and/or staff member(s).

(i) For school-age child care programs, the following shall apply:

1. The center shall adopt, implement and maintain on file a written policy providing for the direct involvement of parents of enrolled children in the center's operation and activities. The policy shall include:

i. Option (h)1i, ii or iii above; or

ii. Annual open house to which parents are invited for the purpose of observing the program; or

iii. Individual parent/staff conferences.

2. The center shall advise the parents of enrolled children of the center's policy for serving meals and snacks when the center is operating on days when the child's school is not in session.

SUBCHAPTER 7. HEALTH REQUIREMENTS

10:122-7.1 Illnesses/communicable diseases

(a) A center that seeks to serve any children who have any of the illnesses, symptoms of illnesses or diseases specified in (c) and (d) below shall meet all applicable provisions of this subchapter and all provisions of N.J.A.C. 10:122-8.

(b) Under no circumstances shall any center serve or admit any child who has any illness, symptom of illness or disease that a physician has determined require the child to be:

1. Confined to home under a physician's immediate care; or

2. Admitted to a hospital for medical care and treatment.

(c) The following provisions relate to illness and/or symptoms of illness:

1. A center serving well children shall not permit a child who has any of the illnesses or symptoms of illness specified in (c)1i through xv below to be admitted to the center on a given day unless medical diagnosis from a licensed physician, which has been communicated to the center in writing, or verbally with a written follow-up, indicates that the child poses no serious health risk to himself or herself or to other children. Such illnesses or symptoms of illness shall include, but not be limited to, any of the following:

i. Severe pain or discomfort;

ii. Acute diarrhea, characterized as twice the child's usual frequency of bowel movements with a change to a looser consistency within a period of 24 hours;

iii. Two or more episodes of acute vomiting within a period of 24 hours;

iv. Elevated oral temperature of 101.5 degrees Fahrenheit or over or axillary temperature of 100.5 degrees Fahrenheit or over in conjunction with behavior changes;

v. Sore throat or severe coughing;

vi. Yellow eyes or jaundiced skin;

vii. Red eyes with discharge;

viii. Infected, untreated skin patches;

ix. Difficult rapid breathing;

x. Skin rashes, excluding diaper rash, lasting more than one day;

xi. Weeping or bleeding skin lesions that have not been treated by a physician or nurse;

xii. Swollen joints;

xiii. Visibly enlarged lymph nodes;

xiv. Stiff neck; or

xv. Blood in urine.

2. Once the child is symptom-free, or a licensed physician indicates that the child poses no serious health risk to himself or herself or to other children, the child may return to the center.

3. If a child who has already been admitted to the center manifests any of the illnesses or symptoms of illness specified in (c)1 above, the center shall remove the child from the group of well children to a separate room or area, as specified in N.J.A.C. 10:122-5.2(q)4, until:

i. He or she can be taken from the center; or

ii. The director or his or her designee has communicated verbally with a licensed physician, who indicates that the child poses no serious health risk to himself or herself or to other children, at which time the child may return to the group.

(d) The following provisions relate to excludable communicable diseases:

1. The center shall not permit a child or staff member with an excludable communicable disease, as specified in the table below, to be admitted to or remain at the center, until:

i. A note from the child's or staff member's licensed physician states that the child or staff member, respectively, has been diagnosed and presents no risk to himself, herself, or to others; or

ii. The center has contacted the State Department of Health's Communicable Disease Program or local health department pediatric health consultant and is told the child or staff member poses no health risk to others.

TABLE OF EXCLUDABLE COMMUNICABLE DISEASES

Respiratory Illnesses	Gastro-Intestinal Illnesses	Contact Illnesses
Chicken Pox	Giardia Lamblia†	Impetigo
German Measles†	Hepatitis A†	Lice
Hemophilus Influenzae†	Salmonella†	Scabies
Measles†	Shigella†	
Meningococcus†		
Mumps†		
Strep Throat		
Tuberculosis†		
Whooping Cough†		

†Reportable diseases, as required by N.J.A.C. 10:122-7.10(a).

10:122-7.2 Attendance by children and/or staff members known to be infected with Human Immunodeficiency Virus (HIV)

(a) The center should admit a child known to be infected with HIV (also known as HTLV-III or LAV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), to the center.

(b) The center should not exclude a child known to be infected with HIV in order to protect him or her from possible exposure to the infectious diseases of other persons at the center.

(c) The center should not exclude a child solely for the reason that such individual lives with or is related to a person known to be infected with HIV.

(d) The director shall maintain the confidentiality of any child or staff member known to be infected with HIV.

(e) The center shall not require the routine medical screening of children or staff members in a center to detect the presence of HIV.

10:122-7.3 Health and immunization requirements for children

(a) For early childhood programs, the following shall apply:

1. Each child not enrolled in a public or private school shall have had a health examination performed by a licensed physician within:

i. Six months prior to admission, for children who are 2½ years of age or younger; or

ii. One year prior to admission, for children above 2½ years of age.

2. For each child not enrolled in a public or private school, the center shall maintain on file at the center a record of the health examination documented by the physician. The record shall include:

i. The name and address of the examining physician;

ii. The child's medical history indicating, when applicable:

(1) Information on any condition or handicap affecting the child's health; and

(2) Any recommendations for needed medical treatment and/or program or environmental modifications, which the center shall follow, including special requirements as to diet, rest, allergies, avoidance of certain activities, and other care; and

iii. An up-to-date immunization record appropriate to the child's age, or documentation that the child is under a prescribed medical program to obtain immunizations, in accordance with the provisions of N.J.A.C. 8:57-4.

3. For children enrolled in a public or private school, the center shall obtain a written statement from each child's parent indicating:

i. That the child is in good health and can participate in the normal activities of the program; and

ii. Any conditions or specific needs that may require special accommodations.

4. The center shall ensure that the record specified in (a)2 above has been submitted to the center, either:

i. Upon the child's admission; or

ii. Within 30 days of the child's admission, if the parent cannot obtain prior documentation, provided that upon the child's admission, the parent provides a written statement:

(1) Indicating that the requirements in (a)1 and 2ii above have been met; and

(2) Giving the information required in (a)2ii(2) above, when applicable.

5. If immunizations are contraindicated for medical reasons, the center shall require the parent to submit to the center a written statement from a licensed physician attesting to the following:

i. The reason the immunization is medically contraindicated; and

ii. The specific time period that the immunization is medically contraindicated.

6. Any child whose parent objects to a physical examination, immunization or medical treatment for his or her child on grounds that it conflicts with the tenets and practice of a recognized religion of which the parent(s) or child is an adherent or member shall be exempt from complying with such requirements, provided that the parent(s) submits to the center upon the child's admission a signed written statement that the physical examination, immunization or medical treatment interferes with the free exercise of the child's religious rights.

7. The immunization exemption may be suspended by the Bureau during the existence of a health emergency, as determined by the State Commissioner of Health.

(b) For school-age child care programs, the following shall apply:

1. The center shall obtain a written statement from each child's parent indicating:

i. That the child is in good health and can participate in the normal activities of the program; and

ii. Any conditions or special needs that may require special accommodations.

10:122-7.4 Health requirements for staff members

(a) Prior to or upon beginning work at the center, each staff member whose job duties require contact with the children for at least 20 percent of the center's weekly operating hours shall take a Mantoux tuberculin skin test with five TU (tuberculin units) of PPD tuberculin, except that the staff member shall have a chest x-ray taken if he or she has had a previous positive Mantoux tuberculin test. The staff member shall submit to the center written documentation of the results of the test and/or x-ray.

1. If the Mantoux tuberculin test result is insignificant (zero to nine millimeters (mm) of induration), no further testing shall be required. The Bureau or center may at any time require a staff member to retake the Mantoux tuberculin test if there is reason to believe or suspect that the staff member may have contracted tuberculosis or if the State Department of Health recommends retesting.

2. If the Mantoux tuberculin skin test result is significant (10 or more mm of induration), the individual shall have a chest x-ray taken. If the chest x-ray shows significant results, the staff member shall not come in contact with the children unless he or she submits to the center a written statement from a licensed physician certifying that he or she poses no threat of tuberculosis contagion.

(b) Prior to beginning work, each staff member whose job duties require contact with the children for at least 20 percent of the center's weekly operating hours shall submit a written statement from a licensed physician, indicating that he or she is in good health and poses no health risk to persons at the center. Such statement shall be based on a medical examination within the six months immediately preceding such person's working at the center.

(c) The center shall maintain on file the results of each staff member's:

1. Mantoux tuberculin test and/or chest x-ray when indicated; and

2. Physical examination.

(d) The sponsor or director shall exclude a staff member who:

1. Exhibits the illnesses or symptoms of illness or diseases specified in N.J.A.C. 10:122-7.1(c)1 and (d); or

2. Appears to be physically, emotionally or mentally impaired or who appears to have a drug-induced or alcohol-induced condition that would endanger the health, safety, and well-being of a child while the child is in the staff member's care. The director shall document the action taken to exclude the staff member and maintain such documentation on file. The center shall not permit the staff member to return to the center until the condition is no longer present.

(e) When the affected staff member specified in (d) above serves as the director, then the sponsor shall take the necessary action specified above.

(f) When the affected staff member specified in (d) above is the sponsor, then the Bureau shall take the necessary action specified above.

10:122-7.5 Administration and control of prescription and non-prescription medicines

(a) Centers that choose not to administer medication to a child shall inform the parents of this policy prior to the child's enrollment.

(b) For centers that choose to allow prescription and non-prescription medication to be dispensed to a child, the following shall apply:

1. Medication shall be administered only after receipt of written approval from the child's parent(s).

2. The director shall designate those staff members who are authorized to administer medication to or supervise self-administration of medication by those children whose parent(s) authorize it.

3. All medication shall be kept either in a locked cabinet or in an area that is inaccessible to the children.

4. The director shall ensure that the staff member(s) responsible for administering medication are informed of every child's medication needs.

5. Any prescription medication for a child shall be:

i. Prescribed in the name of and specifically for the child; and

ii. Stored in its prescription container, which has been labeled with the child's name, the name of the medication, the date it was prescribed or updated and directions for its administration.

6. The center shall limit the dispensing of non-prescription over-the-counter medication to the following types of medicines, which shall be dispensed in accordance with the recommended dosage, age and/or weight of the child, as indicated on the label:

i. Antihistamines/decongestants;

ii. Acetaminophens (aspirin substitutes);

iii. Cough suppressants; and

iv. Topical ointments.

7. The center may permit the dispensing of non-prescription medication other than those listed in (b)6 above if the child's physician authorizes it in writing.

8. Unused medication shall be returned to the parent(s) when no longer being administered.

9. The center shall maintain on file a record of the following:

i. The child's name and parental authorization for the center to administer medication;

ii. The name of the medication;

iii. The condition for which the medication is being used;

iv. The instructions for administration, including the dosage and frequency;

v. The time and by whom medication was administered to a child; and

vi. Any adverse effect the medication can have or has had on the child.

(c) For early childhood programs, the following shall apply:

1. Centers that choose to administer medication shall ensure that all medication is administered by designated staff.

(d) For school-age child care programs, the following shall apply:

1. Centers that permit a child to self-administer medication shall:

i. Obtain written authorization for self-administration from the child's parent; and

ii. Ensure that the medication is administered under the supervision of authorized staff.

10:122-7.6 Accident and injury to a child while in the center's care

(a) When an accident or injury requiring professional medical care occurs to a child while in the center's care, the center shall take immediate necessary action to protect the child from further harm and immediately notify the child's parent(s) verbally.

(b) The center shall maintain on file a record of accidents and injuries sustained by a child requiring professional medical care while under the center's supervision. The accident and injury record shall include the following:

1. The name of the child involved in the accident or injury;
2. The date, time, and location of the accident or injury;
3. A written description of the following:
i. The accident;
ii. The injury to the child;
iii. The names of witnesses to the accident or injury; and
iv. The follow-up action taken by the center, including:
(1) Application of first aid; and
(2) Consultation or treatment by a licensed physician, if applicable.

(c) Accidents or injuries not requiring professional medical care shall be reported to the child's parent by the end of the day.

(d) Upon request of the child's parent, the center shall provide a written description of the accident and/or injury by the end of the next operating day.

10:122-7.7 Environmental sanitation requirements

(a) Disinfectants shall be used as follows:

1. The center shall disinfect those items specified in (a)3 below with a solution that shall be either:

i. A commercially prepared disinfectant that indicates it kills bacteria, viruses, and parasites. This solution shall be used in accordance with label instructions; or

ii. A self-made solution consisting of one-quarter cup of household bleach to each gallon of water (one tablespoon per quart), which shall be prepared daily and placed in a labeled, sealed container.

2. All areas to be disinfected shall first be washed with soap and water.

3. The schedule for disinfecting shall be as follows:

i. The following equipment items or surfaces shall be washed and disinfected after each use:
(1) Washcloths made of fabric, when used for cleaning children;
(2) Thermometers;
(3) Items used by a child who becomes ill while at the center; and
(4) Sleeping mats that are not stored separately.

ii. The following items shall be washed and disinfected at least daily:
(1) Toilets and toilet seats;
(2) Sinks and sink faucets;
(3) Drinking fountains;
(4) Water table and water play equipment;
(5) Play tables; and
(6) Smooth surfaced non-porous floors in areas used by children.

iii. The following items shall be washed and disinfected at least weekly:
(1) Cribs, cots, mats, playpens or other Bureau-approved sleeping equipment; and
(2) Sheets, blankets or other coverings.

iv. Tables used by the children for eating shall be washed and disinfected before each meal.

(b) Centers that maintain outside sandboxes or play areas containing sand shall ensure that:

1. Only asbestos-free sand is used; and
2. The sand is maintained in a safe and sanitary manner.

(c) Pets shall be permitted in a center only under the following circumstances:

1. Pets kept by or located in the center, regardless of ownership, shall be:

i. Domesticated and non-aggressive;
ii. Free from disease;
iii. Vaccinated, if applicable, as prescribed by law or local ordinance. The record of the vaccinations shall be maintained on file, along with the name and address of the licensed veterinarian providing care for the pet(s);
iv. If sick, removed from the area(s) occupied by children, until the pet has been examined by a licensed veterinarian and has been diagnosed as presenting no risk to the children;
v. Effectively controlled by leash, command or cage; and
vi. Prohibited from the following areas:
(1) Areas/surfaces used for food preparation, storage and/or service;
(2) Areas used for cleaning or storing of food utensils and dishes; and
(3) Toilet facilities.

2. Animal waste shall be disposed of in sealed plastic bags in the outdoor garbage receptacle.

(d) Smoking shall be prohibited in all rooms, vehicles and outside play areas while such rooms, vehicles and areas are occupied by children.

(e) For early childhood programs, the following shall apply:

1. In addition to the items specified in (a)3 above, the following equipment items or surfaces shall be washed and disinfected after each use:

i. Toilet training chairs that have first been emptied into a toilet;
ii. Sinks and faucets used for rinsing a toilet training chair;
iii. Diapering surfaces;
iv. Toys mouthed by infants and toddlers before being given to another child; and
v. Bottles, nipples and other feeding equipment.

2. All diaper pails and lids shall be disinfected daily.

3. Centers that toilet train children shall:

i. Utilize non-porous toilets, child-size toilets, toilet training chairs (potties) or children's toilet seats for children being toilet trained;
ii. Ensure that toilet training chairs are not used in kitchens or in the immediate area where meals are being served; and
iii. Advise parents of the center's toilet training policy.

4. Poisonous plants shall not be kept in the center or in the outside play area used by the children.

10:122-7.8 Personal hygiene requirements

(a) Handwashing requirements are as follows:

1. The center shall ensure that children wash their hands with soap and running water:

i. Before intake of food;
ii. Immediately after using the toilet or having diapers changed;
iii. Immediately after coming into contact with blood, fecal matter, urine, vomit, nasal secretions or other body fluids or secretions; and
iv. Immediately after coming in contact with an animal's body secretions.

2. When cloth towels are used by children, the towels shall be designated soley for the individual child's use.

3. Staff members shall wash their hands with soap and running water immediately:

i. Before preparing or serving food;
ii. After toileting;
iii. After assisting a child in toileting;
iv. After caring for a child who appears to be sick;
v. After coming in contact with an animal's body secretions; and
vi. After coming into contact with blood, fecal matter, urine, vomit, nasal secretions or other body fluids or secretions.

(b) Staff members shall use disposable rubber gloves, which shall be discarded after each use, when coming into contact with blood or vomit.

(c) Centers that encourage children to brush their teeth while at the center shall individually store toothbrushes in a manner which prevents the toothbrushes from touching each other during storage.

(d) For early childhood programs, the following shall apply:

1. Diapering requirements for centers serving children who are not toilet trained are as follows:

i. Staff members shall ensure that:
(1) Each child's diaper is changed when wet or soiled;
(2) Each child's bottom is washed and dried during each diaper change with an individual disposable wash cloth, paper towel or disposable diaper wipes; and
(3) The staff members' hands are washed after changing each diaper.

ii. Diapering area and surface requirements are as follows:

(1) Diapering shall not take place in an area or on a surface used for food preparation, service or eating.

(2) The diapering area shall be within 15 feet of a sink that is not used for food preparation.

(3) The diapering surface shall be flat, smooth, clean, dry, non-absorbent, and in good repair.

iii. Diapering supply requirements are as follows:

(1) A supply of clean diapers shall always be available.

(2) Diapering supplies, including diapers, shall be stored in an area out of the children's reach but easily accessible to staff members during a diaper change.

(3) Equipment used for cleaning the diapering surface shall be restricted for use in this area only and shall be disposable or laundered in hot soapy water.

(4) Staff members who use disposable rubber gloves during a diaper change shall dispose of these gloves after each use and shall wash their hands.

iv. Soiled diapers shall be disposed of as follows:

(1) Soiled disposable diapers shall be placed in a closed container that is lined with a leakproof or impervious lining. Such diapers shall be removed from the center daily and placed in a closed garbage receptacle outside the building.

(2) Soiled non-disposable diapers shall be placed in a sealed plastic container that has been labeled with the child's name. Such diapers shall be returned to the child's parent at the end of that day.

2. Clothing requirements are as follows:

i. A child's clothing shall be changed when wet or soiled.

ii. The center shall ensure that a change of clothing is provided for each child.

iii. Soiled clothes shall be:

(1) Placed in a sealed plastic container that has been labeled with the child's name and returned to the child's parent at the end of that day for laundering; or

(2) Laundered at the center in a washing machine.

iv. For clothing soiled with fecal matter, the stool shall be emptied into the toilet.

10:122-7.9 Illness log

(a) For early childhood programs, the following shall apply:

1. The center shall maintain on file a log of the initial illnesses, symptoms of illness or diseases that are exhibited by each child, as specified in N.J.A.C. 10:122-7.1(c) and (d). This illness log shall include:

i. The child's name;

ii. The date and time the illness, symptoms of illness or diseases were observed at the center, or the date and time the center was notified of the child's illnesses, symptoms of illness or diseases by the parent;

iii. A description of the symptoms of illness manifested by the child;

iv. The action taken by the center to assist:

(1) The child who is demonstrating symptoms of illness; and/or

(2) The director in determining if exclusion of the child from the center is necessary;

v. Any significant change in the child's symptoms of illness; and

vi. The date, if applicable, that:

(1) The child was removed from the center;

(2) The child returned to the center with a licensed physician's note attesting to the child's admissibility to the center and recovery from a reportable disease, as specified in N.J.A.C. 8:57; or

(3) The child returned to the center symptom-free.

10:122-7.10 Reporting of illnesses, injuries, and reportable diseases

(a) The director, upon learning that an enrolled child or staff member at the center has been diagnosed as having contracted or is suspected of having a reportable disease, as specified in N.J.A.C. 10:122-7.1(d), shall report this knowledge by the next working day to the following:

1. The local health department; and

2. The Bureau of Licensing.

(b) The director shall report the occurrence of any injury or illness that results in the admittance to a hospital or death of a child while under the center's supervision to the Bureau by the next working day after the center learns of the occurrence.

(c) The director, having knowledge that a child has been injured by a dog, cat or other animal that is kept by or located at the center and when no physician attends such child, shall, within 12 hours of the injury, report the name, age, sex, and address of the child to the local health department.

10:122-7.11 Information to parents regarding the management of communicable diseases

(a) Each center shall develop a written policy on the management of communicable diseases. This policy shall include the following:

1. The list of illnesses and/or symptoms of illness for which a child will be separated from the group and possibly sent home, as specified in N.J.A.C. 10:122-7.1(c);

2. The list of diseases for which a child will not be readmitted to the center unless accompanied by a statement from the child's licensed physician, as specified in N.J.A.C. 10:122-7.1(d); and

3. Assurance that during any outbreak of an excludable disease at the center, as specified in N.J.A.C. 10:122-7.1(d), each parent whose child may have been exposed to the disease shall receive a written notice of the outbreak.

(b) A copy of the center's policy on the management of communicable diseases shall be given to the parent of each child enrolled in the center.

(c) Centers serving children who are sick shall comply with the requirements for information to parents, as specified in N.J.A.C. 10:122-8.5(b).

SUBCHAPTER 8. REQUIREMENTS FOR CENTERS SERVING SICK CHILDREN

10:122-8.1 Requirements for all centers serving sick children

(a) The provisions of this subchapter shall apply to any center that chooses to serve the following:

1. Only children who have illnesses, symptoms of illness or diseases, as specified in N.J.A.C. 10:122-7.1(c) and (d); or

2. Some children who have illnesses, symptoms of illness or diseases, as specified in N.J.A.C. 10:122-7.1(c) and (d), as part of a sick child care component of a center primarily serving well children.

(b) A center as set forth in (a) above shall also comply with all applicable provisions of this chapter.

(c) The center shall maintain on file written policies and procedures governing its operation, including:

1. Those categories of illness for which the center will provide care;

2. The ages of children who will be served;

3. The center's infection control procedures;

4. The center's admission criteria, which shall include provisions for conducting either:

i. A medical evaluation of arriving children by a New Jersey licensed physician; or

ii. A physical assessment, known as a triage, of arriving children by a registered nurse;

(1) The triage shall include, as appropriate to the demonstrated symptoms, an assessment of the child's temperature; pulse; respiration; skin; eyes; nose; throat; mouth; chest; abdomen; and/or extremities;

5. A provision encouraging the parents, before bringing the child to the center, to call the center each day to:

i. Describe the child's illnesses, symptoms of illness or diseases; and

ii. Determine if the center has an opening for the child;

6. For centers using a registered nurse as the admitting staff member, the physical assessment criteria that are used to determine:

i. Appropriateness of a child's attendance at the center on that day; or

ii. A child's need to be examined by a licensed physician, prior to being admitted to the center on that day;

7. The criteria and procedures for caring for or releasing children whose illnesses, symptoms of illness or diseases have worsened;

8. Methods and frequency of identifying and recording symptomatic changes throughout the day;

9. The preparation, frequency and serving of meals that are appropriate for the child's illnesses, symptoms of illness or diseases; and

10. The center's policy on communicating with parents concerning the child's illnesses, symptoms of illness or diseases.

(d) The center shall arrange for a New Jersey licensed physician to serve as its consulting physician, providing medical advice and assistance on an on-call basis.

(e) The center shall have a governing board or an advisory board, which shall oversee the development of and approve in writing its policies and procedures, as specified in (c) above. The governing or advisory board shall include at least two of the following licensed health professionals:

1. A physician licensed by the New Jersey Board of Medical Examiners; and/or

2. A registered nurse licensed by the New Jersey State Board of Nursing; and/or

3. A local health official.

(f) The consulting physician shall approve in writing the policies and procedures specified in (c) above.

10:122-8.2 Admission criteria

(a) The center shall not admit a sick child below three months of age unless the child has been seen and diagnosed by his or her licensed physician and the physician indicates in writing that the child can be admitted.

(b) The center shall require that a parent or an adult authorized by the parent accompany each child during admission to the center.

10:122-8.3 Requirements for additional staff for centers serving sick children

(a) The staff requirements for centers serving sick children are as follows:

1. In addition to the staff members required in N.J.A.C. 10:122-4.2, the center shall ensure that a physician licensed by the New Jersey Board of Medical Examiners or a registered nurse licensed by the New Jersey State Board of Nursing is at the center during the hours children are in attendance.

2. The staff member specified in (a)1 above may also serve as the head teacher, group teacher, or program supervisor where applicable, provided that:

i. The person meets the staff qualification requirements for such positions, based on the center size and type, as specified in N.J.A.C. 10:122-4.5(b) through (d); or

ii. The person has two years of work experience with children of the age group being served.

3. In centers that primarily serve well children and provide sick care only as a component of the overall program, the physician or registered nurse, as specified in (a)1 above, shall be required to be at the center for at least 50 percent of the sick care component's daily operating hours, and shall be on call and available to come to the center immediately at all other times, provided that the following conditions are met:

i. The physician or registered nurse is present at all times when children are being admitted to the center;

ii. Sick care is provided only to children who are regularly enrolled in the center's program serving well children;

iii. No more than eight children are served in the sick care component at any one time;

iv. Children under six months of age are not admitted to the sick child care component at any time;

v. A child has attended the center's program serving well children for at least 20 days before being allowed admission to the sick care component;

vi. The physician or registered nurse assesses that no child will be placed at risk during the time when the physician or registered nurse is absent; and

vii. The on-call physician or nurse does not serve as the center's head teacher.

4. In centers specified in (a)3 above, the provisions specified in (a)3i through vii above need not be met if the physician or registered nurse remains at the center during all hours the children are in attendance.

(b) The responsibilities of the staff physician or registered nurse are as follows:

1. The physician or registered nurse, as specified in (a)1 above, shall be responsibile for developing and implementing the center's medical program, including:

i. Conducting the daily admission assessment of each child, as specified in N.J.A.C. 10:122-8.1(c)4;

ii. Maintaining records on each child, as specified in N.J.A.C. 10:122-8.7(a); and

iii. Reviewing and administering medication, as specified in N.J.A.C. 10:122-7.5(b), as applicable for each child.

(c) The following staff/child ratios shall apply:

Age of Child	Staff/Child Ratio
Birth to 3 months of age	1:1
3 months to 18 months of age	1:3
18 months to 2½ years of age	1:5
2½ years of age and above	1:7

(d) Grouping of children shall be as follows:

1. The center shall group children according to the illnesses categorized below:

i. Upper-respiratory;

ii. Gastro-intestinal;

iii. Chicken pox; and

iv. Any other illness that has been included in the center's admission policy.

(e) Additional staff training shall be provided as follows:

1. The center shall provide training for each new staff member upon beginning work at the center and for all staff members annually.

2. Such training shall include:

i. Basic knowledge of first aid principles;

ii. Recognizing the symptoms of illness;

iii. Feeding sick children;

iv. When and how to call for medical advice;

v. Taking children's temperatures;

vi. Any other care that may be required for admissible illnesses and conditions;

vii. Infection control;

viii. Review of center policies and procedures;

ix. Child development, including activities for children who are sick; and

x. Communicating with parents concerning a child's illness.

10:122-8.4 Requirements for additional physical facilities for centers serving sick children

(a) There shall be a minimum of 50 square feet of net indoor floor space for each child.

(b) An individual room or a specific area within a large room, which is separated from other areas of the room by a partition or room divider, shall be available to separate and prevent contact between children who have different illnesses, symptoms of illness or diseases.

(c) Centers whose policies allow for the care of children who have chicken pox or other illnesses that require isolation shall provide an isolation room for these children. Each isolation room shall have the following:

1. Continuous barriers that are floor to ceiling in height; and

2. Its own toilet facility, unless children using the isolation room can reach and use another toilet facility without coming into contact with other children.

(d) The center shall provide soap for handwashing from a liquid soap dispenser.

(e) The center shall conduct monthly fire drills that may, but are not required to, involve children. The drills shall simulate closely the procedures to be followed during an emergency evacuation.

(f) Centers that serve only sick children shall not be required to have the following:

1. An outdoor space for the children's physical activities or its equivalent, as specified in N.J.A.C. 10:122-5.2(s)7; and

2. A room or area in a separate section of the center for children who become ill, as specified in N.J.A.C. 10:122-5.2(q)4.

(g) Centers that have a sick child care component, as specified in N.J.A.C. 10:122-8.1(a)2, shall use separate play rooms and/or areas and separate toilet facilities for sick and well children.

10:122-8.5 Program requirements for centers serving sick children

(a) The center shall develop and provide a variety of children's planned daily activities that are appropriate for the needs and the condition of children who are sick.

(b) The center shall make available to parents of prospective enrollees information in writing on the center's program, including:

1. Illnesses, symptoms of illness or diseases for which the center will provide care;

2. The center's admission criteria; and

3. The center's daily admitting procedures.

10:122-8.6 Sanitation and infection control

(a) The center shall ensure that all washable items of play equipment, supplies and toys that one group of sick children, as specified in N.J.A.C. 10:122-8.3(d), have contacted are washed with soap and water and disinfected before allowing them to be used by another group of sick children.

(b) The center shall ensure that all personal items belonging to a child are returned to the parent each day.

10:122-8.7 Requirements for additional records for centers serving sick children

(a) The center shall maintain on file the following additional records:

1. Admission assessment information on each child, as specified in N.J.A.C. 10:122-8.1(c)4;

2. The written policies and procedures developed by the center, as specified in N.J.A.C. 10:122-8.1(c);

3. The written approval of policies and procedures by the center's governing board or advisory board and by the consulting physician, as specified in N.J.A.C. 10:122-8.1(e) and (f);

4. Documentation of the training provided to all staff members, as specified in N.J.A.C. 10:122-8.3(e); and

5. The information to parents document, as specified in N.J.A.C. 10:122-8.5(b).

SUBCHAPTER 9. TRANSPORTATION REQUIREMENTS

10:122-9.1 Scope; use of private passenger vehicles

(a) The provisions of this subchapter shall apply to:

1. Any center that provides or arranges for the provision of transportation for children:

i. To or from their homes or other prearranged sites and the center; and/or

ii. In connection with an activity (such as a field trip) conducted by or through the auspices of the center; and

2. Any person or agency other than the center that provides or arranges for the provision of transportation for compensation for children to or from their homes and a center.

(b) Any center, person or agency, as defined in (a) above, also shall comply with applicable provisions of New Jersey Division of Motor Vehicles law, pursuant to N.J.S.A. 39:1-1 et seq. and the rules promulgated thereunder, as specified in N.J.A.C. 13.

(c) The center may authorize staff members and/or parents of enrolled children to utilize their own private passenger vehicles to transport children from the center to and from scheduled center field trips, outings or special events (such as visits to the zoo, library, museum) or to transport children from the center to a hospital, clinic or office for medical treatment, pursuant to N.J.S.A. 18A:39-20.1. However, staff members and/or parents may be authorized to do so only if:

1. The vehicle has a capacity of eight or fewer persons;

2. The driver possesses a valid automobile driver's license issued by the New Jersey Division of Motor Vehicles, hereinafter referred to as DMV;

3. The vehicle has a valid motor vehicle inspection sticker issued by DMV;

4. The vehicle owner possesses vehicle liability insurance at least at the minimum amounts required by New Jersey State insurance law, pursuant to N.J.S.A. 17:28-1.1a;

5. The center maintains transportation records on every vehicle utilized for the above, as specified in N.J.A.C. 10:122-9.7(b); and

6. The center ensures that the driver and/or additional adults apply the safety practices, as specified in N.J.A.C. 10:122-9.5(a) through (d) and (g) through (m).

10:122-9.2 Vehicle definitions

(a) A Type I School Bus means a bus with a capacity of 17 to 58 passengers, as indicated by the vehicle manufacturer.

(b) A Type II School Bus means a bus with a capacity of 10 to 16 passengers, as indicated by the vehicle manufacturer.

(c) A Type II School Vehicle means a vehicle with a capacity of nine or fewer passengers, as indicated by the vehicle manufacturer, and a minimum of three side entry doors.

10:122-9.3 Vehicle requirements

(a) For early childhood programs, the following shall apply:

1. The following requirements shall apply to vehicles utilized by a center that provides or arranges for the transportation of enrolled children to and from the center, as specified in N.J.A.C. 10:122-9.1(a).

2. Each Type I School Bus shall:

i. Be equipped with school vehicle Type I, "S1" designated license plates and a valid School Bus inspection sticker issued by DMV; and

ii. Meet the specifications for Type I School Buses prescribed by New Jersey Department of Education rules, as specified in N.J.A.C. 6:21-5, and that were applicable at the time the bus was manufactured.

3. Each Type II School Bus shall:

i. Have school vehicle Type II, "S2" designated license plates and a valid School Bus inspection sticker issued by DMV;

ii. For Type II School Buses manufactured prior to April 1, 1977, meet the specifications prescribed by New Jersey Department of Human Services rules that were applicable at the time the bus was manufactured; and

iii. For Type II School Buses manufactured after April 1, 1977, be painted in the color of uniform national school bus yellow and meet the specifications prescribed by New Jersey Department of Education rules, as specified in N.J.A.C. 6:21-5.

4. Each Type II School Vehicle shall:

i. Have school vehicle Type II, "S2" designated license plates and a valid School Bus inspection sticker issued by DMV;

ii. Have a maximum seating capacity that does not exceed the number of seat belts installed;

iii. Have a minimum seat width allowance of 12 inches per child;

iv. Have seats and back rests securely fastened and facing forward;

v. Allow exiting from any seat in the vehicle with minimum unobstructed clearance of 10 inches;

vi. Have no seat that requires the folding of any seat ahead of it in order to permit exiting. Seats that are not facing forward or that require the folding of any seat ahead of them in order to permit exiting shall be removed or bolted down;

vii. Have seats upholstered with springs or foam rubber;

viii. Have padding around exposed metal bars in the vehicles to prevent child impact;

ix. Have an operable heater capable of maintaining a temperature of 50 degrees Fahrenheit; and

5. Each vehicle used by a center to provide transportation of enrolled children to and from the center, as specified in N.J.A.C. 10:122-9.1(a), shall be equipped with the following:

i. Three triangular portable red reflector warning devices;

ii. A fully charged fire extinguisher, with a gauge and with a minimum underwriters' rating of 2A 10BC, which shall be located

at the front and securely mounted to the right of the driver in a way that does not constitute an obstruction or hazard to the passengers;

iii. All-weather radial or snow tires from November 15 to April 1; and

iv. A removable, moisture-free and dust-proof first-aid kit, which shall be located in an accessible place within the vehicle. A sign indicating its location shall be placed on the dashboard. The first-aid kit shall contain the following items:

(1) Two single units, one inch by 2½ yards adhesive tape;

(2) Two single units, sterile gauze pads, three inch by three inch (12 per unit);

(3) One single unit, ¾ inch by three inch adhesive bandage (100 per unit);

(4) One single unit, two inch bandage compress (12 per unit);

(5) One single unit, three inch bandage compress (12 per unit);

(6) Two single units, two inch by six yards sterile gauze roller bandage;

(7) Two single units, nonsterile triangular bandage, approximately 40 inch by 36 inch by 54 inch with two safety pins;

(8) Three single units, sterile gauze, 36 inch by 36 inch (U.S.P. 2428 count);

(9) Three single units, sterile eye pad (one per unit);

(10) One pair of scissors;

(11) A pad and sharpened pencil;

(12) One mouth to mouth airway; and

(13) One pair of latex gloves.

(b) For school-age child care programs, the following shall apply:

1. Centers may use vehicles other than school buses or school vehicles provided that the vehicles:

i. Have a valid motor vehicle inspection sticker issued by DMV;

ii. Transport no more children than the manufacturer's capacity specifications indicate and the maximum number of seat belts installed;

iii. Have seats and back rests securely fastened;

iv. Have padding around exposed metal bars in the vehicles to prevent child impact;

v. Have an operable heater; and

vi. Are equipped with the following:

1. Three triangular portable red reflector warning devices;

2. A fully charged fire extinguisher, with a gauge and with a minimum underwriters' rating of 2A 10BC, which shall be located at the front and securely mounted to the right of the driver in a way that does not constitute an obstruction or hazard to the passengers;

3. All-weather radial or snow tires from November 15 to April 1; and

4. A removable first-aid kit, which shall be located in an accessible place within the vehicle. A sign indicating its location shall be placed on the dashboard. The first-aid kit shall contain the items specified in (a)5 above.

10:122-9.4 Driver licensing requirements

(a) If a center uses a Type I School Bus, Type II School Bus or a Type II School Vehicle, the center shall:

1. Meet all appropriate rules of the Division of Motor Vehicles (DMV), Department of Education and/or Department of Human Services; and

2. Ensure that the drivers of such vehicles possess a valid Class B license for the New Jersey Type I School Bus, or possess a valid Class C license for the New Jersey Type II School Bus or an out-of-state equivalent license, as approved by the DMV.

(b) For school-age child care programs, a center using a vehicle with a capacity of 17 or more passengers shall ensure that the drivers of such vehicles possess the appropriate commercial driver's license, as required by DMV.

10:122-9.5 Vehicle-related safety practices

(a) Children shall never be left unattended in a vehicle.

(b) Children shall be accepted and discharged from the curbside of the vehicle.

(c) The interior and exterior of each vehicle shall be maintained in clean and safe condition, with clear passage to operable doors.

(d) All vehicles that are utilized to transport children below 18 months of age shall be equipped with car seats (child passenger restraint systems) that meet Federal motor vehicle safety standards, in accordance with provisions of DMV law, pursuant to N.J.S.A. 39:3-76.2a.

(e) The driver shall not transport more persons, including children and adults, than:

1. The occupancy of the Type I School Bus, as indicated by the vehicle manufacturer; or

2. The occupancy of the Type II School Bus or School Vehicle or other approved vehicle, as determined by the number of operable seat belts.

(f) The driver of and/or additional adult(s) on the Type I School Bus shall ensure that:

1. All passengers are seated and remain seated when the bus is in motion; and

2. All passengers below 18 months of age are secured in the proper restraint system, as specified in (d) above, when the bus is in motion.

(g) The driver of and/or additional adult(s) on the Type II School Bus, School Vehicle and private passenger vehicle shall ensure that:

1. All passengers are seated and remain seated when the vehicle is in motion; and

2. All passengers are secured in an operable seat belt or proper restraint system, as specified in (d) above, when the vehicle is in motion.

(h) There shall be no standees in any vehicle transporting children.

(i) The driver shall conduct two emergency evacuation drills each year for passengers who ride the Type I or Type II School Bus.

(j) The driver shall conduct a daily check of the vehicle, which shall include all safety equipment, to ensure that the vehicle is in sound operating condition.

(k) The driver shall conduct a check of the vehicle, after each run is completed, to ensure that no child has been left on the vehicle.

(l) Smoking shall be prohibited in all vehicles when occupied by children.

(m) For early childhood programs, the driver or additional adult(s) shall ensure that each child discharged from the vehicle is received by his or her parent or person designated by a child's parent.

(n) For school-age child care programs, centers transporting 12 or more children shall have a minimum of one adult in addition to the driver on each vehicle.

10:122-9.6 Vehicle insurance

Each center or person providing transportation services, as specified in N.J.A.C. 10:122-9.1(a), shall secure and maintain vehicle liability insurance for bodily injury or death in minimum amounts of $300,000 per person and $500,000 per accident.

10:122-9.7 Transportation records

(a) The center shall maintain on file a record of each child transported, the name and address of each driver, a photostatic copy of his or her valid commercial driver's license and the year, make and model of each school bus or school vehicle used.

(b) For center-authorized drivers providing periodic transportation in private vehicles, the center shall maintain on file a checklist indicating that the provisions specified in N.J.A.C. 10:122-9.1(c)1 through 4 have been met.

(c) The center shall maintain on file the names and addresses of the person(s) designated as the additional adult(s) and the license numbers of the school bus(es) or vehicle(s) to which they are assigned.

(d) The center shall maintain on file inspection and maintenance records for each school bus or school vehicle used by the center to transport children. Such records shall include:

1. The vehicle's New Jersey registration number, make, serial number, and the number of ply and size of all tires;

2. The nature and date of every vehicle inspection and repair; and

3. For vehicles that have been leased or otherwise contracted for, the name and address of the leaser or contractor furnishing the vehicle.

(e) The records specified in (d) above shall be retained in the center's files for the life of the vehicle.

(f) Documentation of emergency evacuation drills for all passengers who ride the Type I or Type II School Bus shall be maintained in a log containing the following information:

1. The date of the drill;

2. The number of passengers;

3. The time taken to evacuate the bus; and

4. The signature of the person conducting the drill.

(g) If transportation services are provided by the center, or by a firm under contract to or other arrangement with the center, the center shall maintain on file a copy of its own vehicle liability insurance, or of that firm's name and vehicle liability insurance coverage in the amount(s) specified in N.J.A.C. 10:122-9.6.

(h) For school-age child care programs, the following shall apply:

1. The center shall obtain written authorization from the parent or guardian before transporting a child to or from the center.

10:122-9.8 Special requirements for physically handicapped, non-ambulatory children

(a) For centers providing or arranging for transportation services for physically handicapped children who are non-ambulatory, the following additional requirements shall be met:

1. A ramp device or a hydraulic lift shall be provided with a lift minimum pay load of 600 pounds;

2. Wheelchairs shall be securely fastened and face forward;

3. The arrangements of the wheelchairs shall not impede access to the emergency or exit door;

4. If a ramp device is installed, it shall:

i. Have a non-skid surface;

ii. Be securely stored and protected from the elements when not in use; and

iii. Have at least three feet of length for each foot of incline;

5. Seat belts or other restraints approved by DMV shall be installed for each passenger, including those seated in wheelchairs; and

6. Any aisle leading from a wheelchair position to the emergency exit door shall be a minimum width of 30 inches.

10:122-9.9 Special requirements to prevent child abuse and/or neglect

(a) For early childhood programs, the following shall apply:

1. When seven or more children who are 2½ years of age or older are being transported, there shall be one adult in addition to the driver who remains in the vehicle when it is in motion, and who remains within sight of the vehicle when it has stopped to accept or discharge children, from the time the first child is picked up until the last child has reached his or her destination.

2. When between four and 12 children who are below 2½ years of age are being transported, there shall be one adult in addition to the driver who remains in the vehicle when it is in motion, and who remains within sight of the vehicle when it has stopped to accept or discharge children, from the time the first child is picked up until the last child has reached his or her destination.

3. When 13 or more children who are below 2½ years of age are being transported, there shall be two adults in addition to the driver who remain in the vehicle when it is in motion, and who remain within sight of the vehicle when it has stopped to accept or discharge children, until fewer than 13 children remain, at which time one adult in addition to the driver shall remain until the last child has reached his or her destination.

INSURANCE

(a)

SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Proposed Amendments: N.J.A.C. 11:21-1.2 and 4.1, and Exhibits A, F, G, H, I and K of the Appendix to N.J.A.C. 11:21

Proposed New Rules: Exhibits V, W, X, Y, Z and AA to the Appendix to N.J.A.C. 11:21

Authorized By: New Jersey Small Employer Health Benefits Program Board, Maureen Lopes, Chairperson.

Authority: N.J.S.A. 17B:27A-17 et seq., as amended by P.L. 1993, c.162, Section 16.

Proposal Number: PRN 1993-632.

A **public hearing** concerning these proposed regulations will be held by the Small Employer Health Benefits Board on Wednesday, November 3, 1993 at 9:30 A.M. at the following address:

Mary G. Roebling Building
Second Floor
20 West State Street
Trenton, NJ 08625

Submit written comments by November 8, 1993 to:

Interim Administrator
New Jersey Small Employer Health Benefits Program
SEH Box 1
c/o The Prudential Insurance Co. of America
P.O. Box 4080
Iselin, New Jersey 08830

The agency proposal follows:

Summary

These amendments and new Exhibits are being proposed pursuant to the Small Employer Health Benefits Program, P.L. 1992, c.162 enacted November 30, 1992 and amended June 30, 1993, P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.) ("The Act").

The Small Employer Health Benefits Program ("SEH") Board of Directors ("Board") is proposing these amendments and new Exhibits in accordance with the procedure set forth in P.L. 1993, c.162, Section 16(a) through (f) which sets forth a procedure which the Board may follow to adopt actions, notwithstanding the provisions of P.L. 1968, c.410 (N.J.S.A. 52:14B-1 et seq.). Section 16 generally provides that prior to the adoption of health benefits plans, the Board shall publish notice of its intended action in three newspapers of general circulation, and mail same to those persons and entities specified in Section 16. The Board is further required to forward the notice of intended action and detailed description to the Office of Administrative Law for publication in the New Jersey Register. The Board is required to hold a public hearing on the establishment and modification of health benefits plans, which hearing has been scheduled by the Board for November 3, 1993. The Board is also required to provide all interested persons an opportunity to comment in writing on the intended action. The Board has established November 8, 1993 as the date by which all written comments must be received. The Board will take final action on these proposed amendments immediately following the close of the public comment period. The final action shall be effective on the date the amendments, as adopted by the Board, are submitted to the Office of Administrative Law for publication in the New Jersey Register, or such later date as the Board may establish pursuant to P.L. 1993, c.162, Section 16(e).

In accordance with the Act, insurance companies, health service corporations, hospital service corporations, medical service corporations, health maintenance organizations, and multiple employer arrangements offering health benefits plans for small employer (collectively, "carrier") must offer, as a condition of transacting business in this State, health benefits plans promulgated by the SEH Board. The Board is given broad powers to oversee the program including authority to define the provisions of the small employer health benefits plans.

The amendments and new Exhibits proposed herein are in response to comments received by the Board to its proposed new rules setting forth, among other things, the standard health benefits plans required

to be promulgated pursuant to N.J.S.A. 17B:27A-33, as well as in response to comments received from the Department of Insurance during its review of the health benefit plans. The rules and Exhibits A through M, proposed July 12, 1993, and appearing at 25 N.J.R. 3597-3681, have been adopted by the Board with substantive and technical changes not requiring additional notice and comment. The Board filed its adoption with the Office of Administrative Law on October 15, 1993, and the notice of adoption is published elsewhere in this issue of the New Jersey Register.

The proposed amendments set forth here are changes which the Board determined required new notice subject to a new comment period. The proposed amendments are summarized below.

The definition of "health benefits plan," set forth at N.J.A.C. 11:21-1.2, has been amended to exclude a class of hospital confinement indemnity policies. Concurrently, Exhibits A, F and G have been amended to prohibit coordination of benefits with such excluded hospital confinement indemnity plans when the employee pays the full premium for that plan. These proposed amendments are intended to promote greater consistency between rules adopted by the Department of Insurance (N.J.A.C. 11:4-28) and the Individual Health Coverage Program (N.J.A.C. 11:20-1.2).

Several amendments are being proposed to N.J.A.C. 11:21-4.1. First, at proposed N.J.A.C. 11:21-4.1(a)1 and (b)1, carriers are being allowed to use language alternative to the utilization review provisions adopted by the Board (if they use utilization review at all). Such alternative language, however, is subject to the same review and approval procedures applicable to the standard health benefits plan.

Second, at proposed N.J.A.C. 11:21-4.1(e) through (j), carriers are being required to provide employees with standard certificates of coverage, appropriate to the standard health benefits plan under which the employee is insured or enrolled.

Several amendments are being proposed to Exhibits A, F and G (that is, Plan A, B, C, D, E and HMO Plan). These include:

a. The definition of "Experimental and Investigational" is being proposed for amendment to alter the criteria used to determine whether to consider covering charges for prescription drugs used for purposes other than that for which they were approved by the FDA (if approved by the FDA).

b. The definition of "Reasonable and Customary" is proposed for amendment to alter the criteria of determining the appropriate level at which to reimburse provider charges.

c. The paragraph regarding covered transplants is being proposed for amendment to include coverage of charges related to autologous bone marrow transplants used with high dose chemotherapy treatment of breast cancer, when the covered person is receiving such treatments as part of a National Cancer Institute clinical study.

d. The paragraph regarding "Waiting Periods" is being proposed for amendment to make the variable maximum six months at the small employer's option.

Additional amendments are being proposed for Exhibits A and F (Plans A, B, C, D and E), which are summarized as follows:

a. The paragraphs addressing Utilization Review, Required Hospital Stay Review, Required Pre-Surgical Review, Alternate Treatment Features and Centers of Excellence Features are being proposed to become variable features of the contracts.

b. The Payment of Claims provision is being proposed for amendment to include two variable sentences, accommodating the separate statutory rights and obligations of different types of carriers.

c. The Extended Care or Rehabilitation Charges provision is proposed for amendment to make the provision consistent with rules of the Department of Insurance (N.J.A.C. 11:4-16) and current group contract practice.

Additional amendments proposed for Exhibits F and G (Plans B, C, D, E and HMO Plan) regard the Prescription Drug Benefit within the plans. The proposed amendment would make the language of the Prescription Drug provision consistent with the proposed amendments to the definition of "Experimental and Investigational."

An additional proposed amendment to Exhibit A (Plan A) is being made to clarify that the 30 day benefit limit on cognitive and speech therapy is a combined limit, consistent with Plans B, C, D, E and HMO Plan.

Amendments are being proposed to Exhibits H and J, Parts 1, 2 and 3 of each (the Prescription Drug Riders for Plans A, B, C, D, E and HMO Plan). The proposed amendments revise the riders with respect to what prescriptions will be covered to make the riders consistent with the prescription drug benefit in the underlying plan. Definitions are also being revised.

Amendments are being proposed to Exhibit I (the Mental and Nervous Conditions and Substance Abuse Benefits rider) to clarify that when the rider is used, the prescription drug benefit in the underlying plan will cover drugs prescribed for the treatment of the condition.

Amendments are also being proposed to Exhibit K, Parts 1 and 2 (Explanation of Brackets) to explain additional variables being proposed in the foregoing exhibits.

New exhibits to the Appendix to N.J.A.C. 11:21 are being proposed as follows:

Exhibit V is the Employee Certificate for Plan A.

Exhibit W is the Employee Certificate for Plans B, C, D and E.

Exhibit X is the Explanation of Brackets for all of the Employee Certificates.

Exhibit Y is the Employee Certificate for HMO Plan.

Exhibit Z sets forth the Employee Certificate for the prescription drug benefit and mental and nervous condition benefit riders applicable to Plans B, C, D and E.

Exhibit AA sets forth the Employee Certificate for the prescription drug benefit riders applicable to HMO Plan.

Social Impact

The amendments being proposed satisfy three goals: to make the Board's rules and standard health benefits plans consistent with current State and Federal laws (and trends); to revise certain benefits and language in response to concerns expressed by consumers and carriers alike; and to assure internal consistency within the plan designs. The social impact intended is to produce health benefits plans and employee certificates which are more easily understood by the consumer, more easily administered by the carrier, and which provide benefits or services in a reasonably fair and economical fashion. The social impact should be positive for all interested and concerned parties.

Economic Impact

With the exception of the proposed amendment at N.J.A.C. 11:21-4.1(e) through (j), and Exhibits V through AA of the Appendix to N.J.A.C. 11:21, the proposed amendments will have little or no economic impact upon carriers or small employers and their employees. The requirement that carriers provide standardized employee certificates (N.J.A.C. 11:21-4.1(e) through (j) and accompanying Exhibits) will have an economic impact upon carriers, but not an unexpected one. Carriers have to develop employee certificates in any instance and the Board has developed standardized Certificates to correspond to the five health benefits plans and riders.

Carriers should note that the Board intends to make the standard health benefits plans and employee certificates available on disc upon request and for a nominal fee. More information on this will be made available at a later date.

Regulatory Flexibility Analysis

The proposed amendments do not impose additional recordkeeping or reporting requirements, but do impose additional compliance requirements, as described in the foregoing Summary. The additional compliance requirements affect carriers only, and are ones (provision of employee certificates) which should have been anticipated. Although the compliance requirement is new with respect to the SEH Program it is consistent with current industry requirements under New Jersey law. The only difference is that the employee certificates are standardized.

Assuming one or more carriers subject to these proposed amendments are small businesses, as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the Board does not believe relaxation of the compliance requirements of these amendments is warranted. The underlying legislation of the SEH Program is intended to standardize the small employer segment of the insurance market. Different rules applicable to carriers that qualify as small businesses would be inconsistent with this clearly stated legislative intent.

Full text of the proposed amendments follows (additions indicated in boldface **thus**; deletions indicated in cursive brackets {thus}):

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context

clearly indicates otherwise, or as such words and terms are further defined by this chapter.

...

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, insurance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.). **A "health benefits plan" also does not include any group or group type supplemental hospital indemnity benefits program wherein the benefit does not exceed $250.00 per day. A hospital indemnity benefits program does not fail to meet the test therein so long as the benefit paid for the first two days of hospitalization does not exceed that which would be paid under the following formula:**

$$\frac{\text{1st day benefit} - \text{2nd day benefit}}{5} + \text{2nd day benefit} \leq \$250$$

...

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D and E which are set forth in the Appendix to this chapter as Exhibits A through F, subject to the "Explanation of Brackets (Plans A, B, C, D)" set forth in Exhibit K, Part 1 of the Appendix, incorporated herein by reference.

1. Notwithstanding (a) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit K, Part 2 of the Appendix, incorporated herein by reference.

1. Notwithstanding (b) above, a small employer carrier may, upon approval of the Board and subject to the requirements of N.J.S.A. 17B:27A-17 et seq., apply an alternative method of utilization review to small employer health benefits plans issued by such carrier pursuant to this rule.

i. A small employer carrier shall submit its alternative method of utilization review in triplicate to the Board at the address specified at N.J.A.C. 11:21-1.3. The submission shall include an explanation why the alternative method of utilization review is reasonable and a statement that the carrier shall apply the alternative method of utilization review uniformly to all small employer health benefits plans and to all small employers. The submission shall be certified by a duly authorized officer of the carrier.

ii. The Board shall notify the small employer carrier in writing within 60 days of the small employer carrier's filing with the Board whether such request is approved.

iii. The small employer carrier shall have a right of appeal if the Board disapproves the small employer carrier's alternative method of utilization review, in accordance with procedures established by the Board in its Plan of Operation.

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

(e) Members shall use the standard small group health benefits certificate for Plan A which is set forth in the Appendix to this chapter as Exhibit V, subject to the "Explanation of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(f) Members shall use the standard small group health benefits certificate for Plans B, C, D and E which is set forth in the Appendix to this chapter as Exhibit W, subject to the "Explantion of Brackets—Certificate Forms" set forth in Exhibit X, Part 1 of the Appendix, incorporated herein by reference.

(g) Members shall use the standard employee evidence of coverage for HMO Plan which is set forth in the Appendix to this chapter as Exhibit Y, subject to "Explanation of Brackets (HMO Plan)" set forth in Exhibit X, Part 2 of the Appendix, incorporated herein by reference.

(h) Members shall use the Rider—Certificate Forms for Plans B, C, D and E as set forth in the Appendix to this chapter as Exhibit Z, Part 1, "Card/Mail"; Part 2, "Card"; Part 3, "Mail"; and Part 4 "Mental and Nervous Conditions and Substance Abuse Benefits."

(i) Members shall use the Riders—Employee evidence of coverage for HMO Plan as set forth in the Appendix to this chapter as Exhibit AA, Part 1, "Card/Mail"; Part 2, "Card"; and Part 3, "Mail."

(j) All small group health benefits certificates and employee evidences of coverage issued to employees covered under small employer health benefits plans on and after January 1, 1994, shall be issued in accordance with these rules.

EXHIBIT A

...

CLAIMS PROVISIONS

...

PAYMENT OF CLAIMS

...

f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

...

DEFINITIONS

...

Experimental or Investigational means [Carrier] determines a service or supply is:

...

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or

condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information; or

3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

...

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

***Reasonable and Customary* means an amount that is not more than the [lesser of:**

- **the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or**
- **the negotiated fee schedule.]**

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

...

EMPLOYEE COVERAGE

...

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

...

COVERED CHARGES

...

Extended Care or Rehabilitation Charges

...

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. {(Reserved)} **start within 14 days of a Hospital stay; and**

b. be due to the same or a related condition that necessitated the Hospital stay.

...

COVERED CHARGES WITH SPECIAL LIMITATIONS

...

Therapy Services

...

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, *combined,* is limited to 30 visits per Calendar Year.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

...

PREVENTIVE CARE

...

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the *Utilization Review Features* section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any

surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, *by 50%*] if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges *by 50%*], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends *by 50%* as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the *Required Pre-Hospital Review* section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery *by 50%*] if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay

b. spinal cord Injury

c. severe burn over 20% or more of the body

d. multiple injuries due to an accident

e. premature birth

f. CVA or stroke

g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i. terminal illness, with a prognosis of death within 6 months

j. Acquired Immune Deficiency Syndrome (AIDS)

k. chemical dependency

l. mental, nervous or psychoneurotic disorders

m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;

b. the Covered Person's attending Practitioner; and

c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;

b. course of treatment to accomplish the stated objectives;

c. the responsibility of each of the following parties in implementing the plan:

- [DEF]
- attending Practitioner;
- Covered Person;
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" menas one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

. . .

COORDINATION OF BENEFITS

. . .

DEFINITIONS

. . .

"Plan" means any of the following that provide health expense benefits or services:

. . .

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. Group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employer pays part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employee pays the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

EXHIBIT F

...

CLAIMS PROVISIONS

...

PAYMENT OF CLAIMS

...

f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under this Policy to such provider.

...

DEFINITIONS

...

Experimental or Investigational means [Carrier] determines a service or supply is:

...

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information; or

3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

...

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary **means an amount that is not more than the [lesser of:**

- **the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or**
- **the negotiated fee schedule.]**

The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

...

EMPLOYEE COVERAGE

...

[The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] *months of continuous* Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

...

HEALTH BENEFITS INSURANCE

...

Co-Insurance Cap

...

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap [and are combined with Co-Insurance amounts from other covered family members to meet the family's Co-Insurance Cap]. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

...

COVERED CHARGES

...

Extended Care or Rehabilitation Charges

...

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. {(Reserved)} **start within 14 days of a Hospital stay; and**

b. be due to the same or a related condition that necessitated the Hospital stay.

...

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of this Policy.

...

COVERED CHARGES WITH SPECIAL LIMITATIONS

...

Transplant Benefits

...

h. Autologous Bone Marrow and Associated High Dose Chemotherapy only for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  —SCID
  —WISCOT Alldrich
- Subject to [Carrier] Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. *Charges in connection with such treatment of breast cancer which are not Pre-Approved by [Carrier] are Non-Covered Charges.*

IMPORTANT NOTICE

[This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the *Utilization Review Features* section for details.]

[This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the *Alternate Treatment Features* section for details.]

[This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the *Centers of Excellence Features* section for details.]

[What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:
a. he or she enters a Facility other than the specified Facility;
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:
a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In case of an emergency admission, the continued stay review evaluates:
a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges, *by 50%*] if:
a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges *by 50%*], if:
a. [ABC] is not notified of the admission at the times and in the manner described above;
b. the Covered Person does not request a continued stay review; or
c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends *by 50%* as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:
a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the *Required Pre-Hospital Review* section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery *by 50%*] if:
a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- **[DEF]**
- **attending Practitioner;**
- **Covered Person;**
- **Covered Person's family, if any; and**

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]

. . .

COORDINATION OF BENEFITS

. . .

DEFINITIONS

. . .

"Plan" means any of the following that provide health expense benefits or services:

. . .

d. programs or coverages required by law;
e. group or group-type hospital indemnity benefits which exceed $250.00 per day;
f. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employer pays part of the premium; or
g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $250.00 per day or less for which the Employee pays the entire premium; nor
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

EXHIBIT G

. . .

[Carrier]
HMO PLAN

SMALL GROUP HEALTH MAINTENANCE INSURANCE ORGANIZATION CONTRACT

. . .

III. DEFINITIONS

. . .

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition, **as explained below.**

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition **will require that one or more of the following established reference compendia:**

I. The American Medical Association Drug Evaluations;

II. The American Hospital Formulary Service Drug Information; or

III. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

...

REASONABLE and CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

...

IV. ELIGIBILITY

EMPLOYEE COVERAGE

...

[The Waiting Period

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least {____} **[6]** months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least {¬¬} **[6]** months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete {¬¬} **[6]** months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete {¬¬} **[6]** months of continuous Full-Time service with the Employer.]

...

V. COVERED SERVICES AND SUPPLIES

...

c. **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval.

...

23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) **and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.**

...

VIII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS *AND SERVICES*

Purpose Of This Provision

A Member may be covered for health benefits **or services** by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays **or provides**. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed **$250.00** per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employer pays part of the premium;

g. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of **$250.00** per day or less; **nor**

d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"{____} **Subscriber**", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits **or services**.

"Dependent" means a person who is covered by a plan for health benefits **or services**, but not as a {____} **subscriber**.

"Allowable expense" means any necessary, reasonable, and usual item of expense **or service** for health care incurred by a {____} **subscriber** or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a {____} **subscriber**'s or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such

provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the {____} **subscriber** or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a {____} **subscriber** or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a {____} **subscriber** or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first **or provides services**, ignoring all other plans. The secondary plans **than** pay the remaining unpaid allowable expenses, but no plan pays **or provides services** more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays **or provides services** first are as follows:

a. A plan that covers a person as a {____} **subscriber** pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a {____} **subscriber**:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a {____} **subscriber** whose birthday falls later in the Calendar Year pays second. The {____} **subscriber**'s year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits **or services.**

d. For a Dependent child of separated or divorced parents, the following governs which plans pays **or provides services** first when the person is a Dependent of a {____} **subscriber.**

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays **or provides services** first.
- If there is no such court order, then the plan of the natural parent with custody pays **or provides services** before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays **or provides services** before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits **and services,** We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan **or services that should have been provided by this plan** have been made by **or provided** another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount **or equivalent value of services.** And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims **or equivalent services** of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

{____} *SERVICES* FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's {____} **coverage** under this Contract when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense **or eligible services** by:

a. this Contract;

b. PIP; or

c. OSAIC.

"Eligible {____} **Services**" means that {____} **of service provided** for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selection regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits **or provide services** as if it were primary.

{____} *Services* this Contract will {____} *provide* if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will **provide** benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS *AND SERVICES*** section of this Contract will apply if:

- the Member is insured **or covered for services** under more than one insurance plan; and
- such insurance plans **or HMO Contracts** are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the {____} **equivalent value of services** if this Contract had been primary.

. . .

EXHIBIT H
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD/MAIL)

. . .

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

. . .

DEFINITIONS

. . .

Mail Order Program **means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.**

Maintenance Drug **means only a Prescription Drug used for the treatment of chronic medical conditions.**

Participating Mail Order Pharmacy **means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.**

. . .

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is *not* obtained through the Mail Order Program is:

. . .

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. {(Reserved)} **dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy;** and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such changes will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;

b. {(Reserved)} **a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and**

c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

. . .

EXHIBIT H
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

. . .

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

. . .

EXHIBIT H
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE (MAIL)

. . .

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered

Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

...

DEFINITIONS

...

Mail Order Program **means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.**

Maintenance Drug **means only a Prescription Drug used for the treatment of chronic medical conditions.**

Participating Mail Order Pharmacy **means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.**

...

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	NONE
• for Brand Name Drugs	$5.00

...

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

...

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. {(Reserved)} **dispensed by a Participating Mail Order Pharmacy for take-home use; and**

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. {(Reserved)} **a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug; and**

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

...

EXHIBIT I

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:

Group Policy No.:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;

2. The American Hospital Formulary Service Drug Information;

3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

...

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;

...

EXHIBIT K
PART 1

EXPLANATION OF BRACKETS—POLICY FORMS

(PLANS A, B, C, D, E)

...

Areas of variability which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the policy forms.

...

5. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.

6. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

7. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.

{6.}**8.** The Waiting Period provision of the Employee Coverage provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

{7.}**9.** The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

10. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.

11. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.

12. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

...

EXHIBIT K
PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

...

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract forms.

...

7. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the **Employer**. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

...

Full text of the proposed new exhibits follows:

EXHIBIT V

[Carrier] **PLAN A**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	01-01-94

[CERTIFICATE] INDEX

SECTION	PAGE(S)
Schedule of Insurance	
General Provisions	
Claims Provisions	
Definitons	
Employee Coverage	
Dependent Coverage	
Preferred Provider Organization Provisions	
Point of Service Provisions	
Health Benefits Insurance	
Utilization Review Features	
Alternate Treatment Features	
Centers of Excellence Features	
Exclusions	
Continuation Rights	
Conversion Rights for Divorced Spouses	
Effect Of Interaction with a Health Maintenance Organization Plan	
Coordination of Benefits	
Benefits for Automobile Related Injuries	
Medicare as Secondary Payor	
Right To Recovery—Third Party Liability	
Statement of ERISA Rights	
Claims Procedures	

SCHEDULE OF INSURANCE **PLAN A**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500 Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable disease, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500 Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by:	
	a Network Provider	***an Out-Network Provider***
The **Co-Insurance** for the Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

• **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis * for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis * for Hospital days
Charges for Hospice Care	exchange basis * for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
—per Covered Family	$300
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy, and in what amounts.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout the [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;

b. be staffed and equipped to give emergency care; and

c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or

b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or

c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and

b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or

b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means Your:

a. legal spouse;

b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your step-children if such step-children depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligiblity Date means the later of:

a. the Employee's Eligiblity Date; or

b. the date the person first becomes a Dependent.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;

b. laboratory and pathology; and

c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which is:

a. designed and able to withstand repeated use;

b. primarily and customarily used to serve a medical purpose;

c. generally not useful to a Covered Person in the absence of an Illness or Injury; and

d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee or Dependent.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligiblity Date means the later of:

a. the date of employment; or

b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or

b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or

c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA

regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized heath care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and Dependent Coverage sections of the Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c. in accordance with generally accepted medical practice;

d. not for the convenience of a Covered Person;

e. the most appropriate level of medical care the Covered Person needs;

f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods of psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behaviorial abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the

Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"]

Planholder means Your Employer who purchased this group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"]

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance** contained in the Policy and in this [certificate].

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

b. the correction of fractures and dislocations;

c. Reasonable and Customary pre-operative and post-operative care; or

d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal

activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[**We, Us, Our** and [**Carrier**] mean [Carrier].]

[**You, Your and Yours** mean an Employee who is insured under the Policy.]

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or

b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under the Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. termination of the other plan's coverage.

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the date after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your Coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:

a. [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, layoff, leave of absence, and the end of employment.

b. [the date] You stop being an eligible Employee under the Policy.

c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.

d. the last day of the period for which required payments are made for You.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are Your:

a. legal spouse;

b. unmarried Dependent children who are under age 19; and

c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this [certificate].

Your "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your step-children if such step-children depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached the Policy's age limit;

b. the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and

c. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to

make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or
b. the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or
b. the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date You notify [Carrier] and agree to make any additional payments, or

b. the Dependent's Eligbility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

b. If You are not covered for Dependent child coverage on the date the child is born, then You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under the Policy will end on the first of the following dates:

a. [the date] Your coverage ends;

b. the date You stop being a member of a class of Employees eligible for such coverage;

c. the date the Policy ends;

d. the date Dependent coverage is terminated from the Policy for all Employees or for Your class;

e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons;

f. at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment,

services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

Utilization Review

The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note:** Used only if coverage is issued as POS.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Family Deductible Limit

The Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

Co-Insurance Cap

The Policy limits Co-Insuance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles; and
c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;

b. The Policy would have paid benefits for the charges, if the Policy had been in effect;

c. The Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and

d. The Policy starts right after the old plan ends.

Extended Health Benefits

If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or

b. one year from the date the person's insurance under the Policy ends; or

c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Charges while Hospitalized

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board
b. Routine Nursing Care
c. Prescription Drugs
d. Blood transfusions
e. Infusion Therapy
f. Chemotherapy
g. Radiation Therapy
h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care or Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per Period of Confinement, subject to a maximum $2,500 Co-Payment per Calendar Year.

Testing Charges

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred soley due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement, but the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care or Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury which are incurred while the Covered Person is an Inpatient in a Hospital.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first,

[Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;

b. are not business associates of the Practitioner who recommended the Surgery; and

c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospital Care Charges

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospital Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy

The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee. The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under the Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

b. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost

of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the Therapy Services listed below but **only** when provided on an Inpatient basis.

c. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

d. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

e. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person, $300 per Covered Family.

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate] You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 A.M. to 9 P.M. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of their review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**] if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**] if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the Proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%**] if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done; or

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"Catastrophic Illness or Injury" means one of the following:
a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:
a. perform a Pre-Treatment Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

Services for ***ambulance*** for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances.

Charges made by a ***dialysis center*** for dialysis services.

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy.***

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental and Nervous Conditions and Substance Abuse.***

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed *pastoral counselor* in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care

Practitioner visits, except as otherwise stated in the Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible *Provider.*

Services related to *Private-Duty Nursing care,* except as provided under the Home Health Care section of this [certificate].

Prosthetic Devices

The amount of any charge which is greater than a *Reasonable and Customary Charge.*

Services or supplies related to *rest or convalescent cures.*

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, *Routine examinations* or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to *Routine Foot Care.*

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a *social worker,* except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either Federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Covered Person would not have been charged if he or she did not have health care coverage;

d. provided by or in a government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a *war,* declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the United States Social Security Act, he or she must notify the Employer within 30 days

of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group benefits due to any of the reasons stated above; or

b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or

b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;

b. the monthly premium he or she must pay to continue such benefits; and

c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Policy ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Covered Person becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-existing Condition of the Covered Person;

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan.

c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- **Your Employer must allow for a leave of absence under Federal law in which case;**
- **the section applies to You.**

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;

b. the end of a total leave period of 12 weeks in any 12 month period;

c. the date on which Your coverage would have ended had You not been on leave; or

d. the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of the Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or

b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of an interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions

are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;

b. PIP; or

c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

Important Notice

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.

b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse

b. an Employee or insured spouse who is under age 65, or

c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When the Policy is Primary** section below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Policy is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a Federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a Federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT W

[Carrier] **PLANS B, C, D, E**

SMALL GROUP HEALTH BENEFITS [CERTIFICATE]

[[Carrier] certifies that the Employee named [below] is entitled to the benefits described in this [certificate], as of the effective date shown [below], subject to the eligibility and effective date requirements of the Policy.

This [certificate] replaces any and all [certificates] previously issued to the Employee under any group policies issued by [Carrier] providing the types of benefits described in this [certificate].

The Policy is a contract between [Carrier] and the Policyholder. This [certificate] is a summary of the Policy provisions that affect Your insurance. All benefits and exclusions are subject to the terms of the Policy.

POLICYHOLDER:	[ABC Company]
GROUP POLICY NUMBER:	[G-12345]
EMPLOYEE:	[JOHN DOE]
CERTIFICATE NUMBER:	[C-1234567]
EFFECTIVE DATE:	01-01-94
CALENDAR YEAR CASH DEDUCTIBLE	
PER COVERED PERSON:	$250
PER COVERED FAMILY:	$500
COINSURANCE:	20%
COINSURANCE CAPS	
PER COVERED PERSON:	$2,000
PER COVERED FAMILY:	$4,000]

[Secretary President]

[Dividends are apportioned each year.]

CERTIFICATE INDEX

SECTION	PAGE(S)
Schedule of Insurance	
General Provisions	
Claim Provisions	
Definitions	
Employee Coverage	
Dependent Coverage	
Preferred Provider Organization Provisions	
Point of Service Provisions	
Health Benefits Insurance	
Utilization Review Features	
Alternate Treatment Features	

Centers of Excellence Features .....
Exclusions .....
Continuation Rights .....
Conversion Rights for Divorced Spouses .....
Effect Of Interaction with a Health Maintenance Organization Plan .....
Coordination of Benefits .....
Benefits for Automobile Related Injuries .....
Medicare as Secondary Payor .....
Right To Recovery—Third Party Liability .....
Statement of ERISA Rights .....
Claims Procedures .....

SCHEDULE OF INSURANCE **[PLAN B]**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows: 40%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$3,000
Per Covered Family per each Calendar Year	$6,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments

SCHEDULE OF INSURANCE **[PLAN C]**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows: 30%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,500
Per Covered Family per each Calendar Year	$5,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE **[PLAN D]**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows: 20%, **except as stated below**

Exception: for Mental and Nervous and Substance Abuse charges	25%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,000
Per Covered Family per each Calendar Year	$4,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE [PLAN E]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	$150
Per Covered Family	$300, **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:	10%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$1,500
Per Covered Family per each Calendar Year	$3,000, **Note:** Must be individually satisfied by 2 separate Covered Persons

Note: The Co-Insurance Caps **cannot** be met with:
- Non-Covered Charges
- Cash Deductibles
- Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse
- Co-Payments.

SCHEDULE OF INSURANCE EXAMPLE PPO (without Co-Payment)

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by an Out-Network Provider	40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

SCHEDULE OF INSURANCE EXAMPLE PPO (with Co-Payment)

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given by a Network Provider:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible—If treatment, services or supplies are given by an Out-Network Provider

Per Covered Person	[$250, $500, or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts

A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

- if treatment, services or supplies are given by a Network Provider — None
- if treatment, services or supplies are given by an Out-Network Provider — 30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE **EXAMPLE POS**

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given or referred by a PCP:

- Physician Visits — $10
- Emergency Room (waived if admitted within 24 hours) — $50
- Hospital Confinement — $100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible—If treatment, services or supplies are given by a Non-referred Provider

Per Covered Person — [$250, $500, or $1,000]
Per Covered Family — [$500, $1,000 or $2,000] **Note:** Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **Medicare as Secondary Payor,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider) $50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. The Policy's Co-Insurance, as shown below, does not include penalties incurred under the Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for the Policy is as follows:

- if treatment, services or supplies are given by the PCP — None, **except as stated below**
- if treatment, services or supplies are given or referred by a non-referred Provider — 20%, **except as stated below**

Exception: for Mental and Nervous and Substance Abuse charges

- if treatment, services or supplies are given or referred by the PCP — 5%
- if treatment, services or supplies are given by a non-referred Provider — 25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

[PLAN B]

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits) — 120 days
Charges for therapeutic manipulation per Calendar Year — 30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits) — 30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits) — 30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)

- for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1 — $500 per Covered Person
- for all other Covered Persons — $300 per Covered Person

Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	$1,000,000

[PLANS C, D, E]

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable Illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for therapeutic manipulation per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries	Unlimited

GENERAL PROVISIONS

INCONTESTABILITY OF THE POLICY

There will be no contest of the validity of the Policy, except for not paying premiums, after it has been in force for 2 years from the Effective Date.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under the Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of the Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the time the Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.]

MISSTATEMENTS

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to the Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of the Policy, and in what amounts.

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to the Policy as of each Policy Anniversary, if the Policy stays in force by the payment of all premiums to that date. The share will be credited to the Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under the Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under the Policy.

CONFORMITY WITH LAW

Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under the Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by the Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [[Carrier] may honor such direction at [Carrier's] option.] [For covered services from an eligible Facility or Practitioner, [Carrier] will determine to pay either the Covered Person or the Facility or the Practitioner.] The Employee may not assign his or her right to take legal action under the Policy to such provider.

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

A Covered Person cannot bring a legal action against the Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against the Policy after three years from the date he or she files proof of loss.

DEFINITIONS

The words shown below have special meanings when used in the Policy and this [certificate]. Please read these definitions carefully. [Throughout this [certificate], these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before the Policy pays any benefits for such charges. Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges. See the **The Cash Deductible** section of this [certificate] for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under the Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means Your:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this [certificate].

An Employee's "unmarried Dependent child" includes:

a. Your legally adopted children,
b. Your step-children if such step children depend on You for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purposes of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Dependent's Eligiblity Date means the later of:
a. the Employee's Eligiblity Date; or
b. the date the person first becomes a Dependent.

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:
a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and nondiscriminatory manner.

Durable Medical Equipment is equipment which is:
a. designed and able to withstand repeated use;
b. primarily and customarily used to serve a medical purpose;
c. generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date coverage begins under the Policy for an Employee or Dependent.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Policy's conditions of eligibility. Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of the Policy. See also You, Your, Yours.

Employee's Eligibility Date means the later of:
a. the date of employment; or
b. the day after any applicable waiting period ends.

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:
a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition, as explained below.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:
1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative resources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:
a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by the Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a Provider which provides palliative and supportive care for terminally ill or terminally injured people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission; or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized heath care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under the Policy more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and Dependent Coverage sections of the Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c. in accordance with generally accepted medical practice;

d. not for the convenience of a Covered Person;

e. the most appropriate level of medical care the Covered Person needs; and

f. furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

Mental Health Center means a Facility which mainly provides treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission;

b. approved for its stated purpose by Medicare; or

c. accredited or licensed by the state of New Jersey to provide mental health services.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods on psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet the Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in the Policy and in this [certificate], or which are specifically identified as Non-Covered Charges or are otherwise not covered by the Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse midwife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

[PLAN B]

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"].

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"].

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

[PLANS C, D, E]

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under the Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by Your Employer. [Note: If the "Plan" definition is employed, references in this [certificate] to "Policy" should be changed to read "Plan"].

Planholder means Your Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this [certificate] to "Policyholder" should be changed to read "Planholder"].

Policy means the group policy, including the application and any riders, amendments, or endorsements, between Your Employer and [Carrier].

Policyholder means Your Employer who purchased the Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by the Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of the Policy.

Reasonable and Customary means an amount that is not more than the [lesser of:

- the] usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board[; or
- the negotiated fee schedule.]

The Board will decide a standard for what is Reasonable and Customary under the Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance** contained in the Policy and in this [certificate].

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;

b. cardiac care units;

c. neonatal care units; and

d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;

b. the correction of fractures and dislocations;

c. Reasonable and Customary pre-operative and post-operative care; or

d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in the Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[We, Us, Our and **[Carrier]** mean [Carrier].]

[You, Your and Yours mean an Employee who is insured under the Policy.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of the Policy, all of the Policyholder's Employees

who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of the Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet the Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:

a. more than [30] days after the Employee's Eligibility Date; or

b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to the Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under the Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under the Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. termination of the other plan's coverage.

But, the Employee must enroll under the Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

The Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under the Policy from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your Coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments, if any, within [30] days of the Employee's Eligibility Date. If You do this within [30] days of the Employee's Eligibility Date, Your coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your insurance under the Policy will end on the first of the following dates:

a. [the date] You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, layoff, leave of absence, and the end of employment.

b. [the date] You stop being an eligible Employee under the Policy.

c. the date the Policy ends, or is discontinued for a class of Employees to which You belong.

d. the last day of the period for which required payments are made for You.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This [certificate's] benefits provisions explain these situations. Read this [certificate's] provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are Your:

a. legal spouse;

b. unmarried Dependent children who are under age 19; and

c. unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under the Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this [certificate].

Your "unmarried Dependent child" includes:

a. Your legally adopted children,

b. Your stepchildren if such stepchildren depend on You for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

You may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Policy, such a child may stay eligible for Dependent health benefits past the Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached the Policy's age limit;

b. the child became insured by the Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and

c. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send [Carrier] written proof that the child is incapacitated and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when Your coverage does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:

a. enroll a Dependent and agree to make the required payments more than [30] days after the Dependent's Eligibility Date;

b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who You have not elected to enroll; or

c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to the Policy's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Policy and stated at that time that such waiver was because they were covered under another group plan and You now elect to enroll them in the Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, You must enroll Your spouse or eligible Dependent children within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Policy, to be a Late Enrollee, if:

a. You are under legal obligation to provide coverage due to a court order; and

b. You enroll Your spouse or eligible Dependent children within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of the Policy, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. The Dependent's Eligibility Date, or
b. the date You become insured for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:

a. the date You sign the enrollment form; or
b. the date You become insured for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify [Carrier] of a Newly Acquired Dependent within [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date You notify [Carrier] and agree to make any additional payments, or

b. the Dependent's Eligibility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date Your Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover Your newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.

b. If You are not covered for Dependent child coverage on the date the child is born, You must:

- make written request to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under the Policy will end on the first of the following dates:

a. [the date] Your coverage ends;

b. the date You stop being a member of a class of Employees eligible for such coverage;

c. the date the Policy ends;

d. the date Dependent coverage is terminated from the Policy for all Employees or for Your class;

e. the date You fail to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons;

f. at 12:01 A.M. on the date the Dependent stops being an eligible Dependent.

Read this [certificate] carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

The Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by the Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

The Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of the Policy. You should read Your [certificate] carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If You have any questions after reading Your [certificate], You should call [Carrier] [Group Claim Office at the number shown on Your identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of PCPs who are members of the [XYZ] Provider Organization to the Covered Person.

b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. *Service Area* means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for the Policy is the [XYZ] Provider Organization. The Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care Practitioner (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Out-Network Benefits.

[Carrier] provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, the Covered Person may only be eligible for Out-Network Benefits.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by a [XYZ] PO Provider or otherwise, the Covered Person may only be eligible for Out-Network Benefits.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the PO Service Area.

Utilization Review

The Policy has utilization features. See the **Utilization Review Features** section of this [certificate].

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of the Policy.

[**Note:** Used only if coverage is offered as POS.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in the Policy and in this [certificate].

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by the Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by the Policy. And what [Carrier] pays is based on all the terms of the Policy.

Family Deductible Limit

The Policy has a family deductible limit of two cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of the Policy.

Co-Insurance Cap

The Policy limits Co-Insuance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;
b. Cash Deductibles;
c. Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse; and
d. Co-Payments.

There are Co-Insurance Caps for:

a. each Covered Person; and
b. each Covered Family.

The Co-Insurance Caps are shown in the Schedule.

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap. But, all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Once two Covered Persons in a family meet their individual Co-Insurance amounts, [Carrier] will waive the family's Co-Insurance for the rest of that Calendar Year.

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Co-Insurance Cap.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased the Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet the Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which the Policy starts;

b. The Policy would have paid benefits for the charges, if the Policy had been in effect;

c. The Covered Person was covered by the old plan when it ended and enrolled in the Policy on its Effective Date; and

d. The Policy starts right after the old plan ends.

Extended Health Benefits

If the Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under the Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of the Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or

b. one year from the date the person's insurance under the Policy ends; or

c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

[PLAN B]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this [certificate's] **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co-Payment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Co-Payment per Calendar Year.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

[PLANS C, D, E]

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of the Policy. Read the entire [certificate] to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this [certificate's] **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. The Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges

Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. start within 14 days of a Hospital stay; and

b. be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this [certificate].

Extended Care or Rehabilitation Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges:

Subject to [Carrier's] Pre-Approval, when home health care can take the place of Inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);

b. physical therapy;

c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of the Policy and to the following conditions:
a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this [certificate].

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:
a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill or terminally injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness or terminal injury.

"Terminally ill" or "terminally injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill or terminally injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of the Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by the Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:
a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospital Care Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse

[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:
a. a Hospital;
b. a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c. a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

The Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for prenatal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of the Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies

[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood

[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a. a local Hospital if needed care and treatment can be provided by a local Hospital;

b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or

c. transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equpiment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:

a. any purchases without [Carrier's] advance written approval;

b. replacements or repairs; or

c. the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor

[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of the Policy.

X-Rays and Laboratory Tests

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this [certificate's] **Preventive Care** section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does not cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are subject to the Mental and Nervous Conditions and Substance Abuse section of the Policy.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment

[Carrier] covers:

a. the diagnosis and treatment of oral tumors and cysts; and

b. the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:

a. the Injury occurs while the Covered Person is insured under any health benefit plan;

b. the Injury was not caused, directly or indirectly by biting or chewing; and

c. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of the Policy, and the following limitations:

[Carrier] will cover charges for:

a. one baseline mammogram for a female Covered Person, ages 35-39;

b. one mammogram, every 2 years, for a female Covered Person, ages 40-49, or more frequently, if recommended by a Practitioner; and

c. one mammogram, every year, for a female Covered Person ages 50 and older.

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any [30] day enrollment period provided for in the Policy. See this [certificate's] EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee. The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under the Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by the Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a Covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under the Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in the Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under the Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under the Policy starts. If the Employer has included an eligibility waiting period in the Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

b. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

c. *Dialysis Treatment*—the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

g. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

i. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss or limb.

Coverage for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy*—subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to:

a. $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and

b. $300 per Covered Person for all other Covered Persons.

These charges are not subject to the Cash Deductible or Co-Insurance.

Therapeutic Manipulation

[Carrier] limits what [Carrier] covers for therapeutic manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. [Carrier] includes a condition under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. Covered Charges for the treatment of Mental and Nervous Conditions and Substance Abuse include charges incurred for Prescription Drugs.

The Covered Person must pay the Co-Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

Transplant Benefits

[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a. Cornea
b. Kidney
c. Lung
d. Liver
e. Heart
f. Pancreas
g. Allogeneic Bone Marrow
h. Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:

- Leukemia
- Lymphoma
- Neuroblastoma
- Aplastic Anemia
- Genetic Disorders
  —SCID
  —WISCOT Aldrich
- Subject to [Carrier] Pre-Approval, breast cancer, if the Covered Person is participating in a National Cancer Institute sponsored clinical trial. **Charges in connection with such treatment of breast cancer which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

IMPORTANT NOTICE

[The Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under the Policy. See the **Utilization Review Features** section for details.]

[The Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs

in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.]

[The Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.]

[What [Carrier] pays is subject to all of the terms of the Policy. Read this [certificate] carefully and keep it available when consulting a Practitioner.

If You have any questions after reading this [certificate], You should [call The Group Claim Office at the number shown on Your identification card.]

The Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review Features.]

[UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with the Policy's utilization review features, he or she will not be eligible for full benefits under the Policy.

Compliance with the Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under the Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of the Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of the Policy is not payable under the Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]]

[REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under the Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives, like home health care or other outpatient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;

b. the named attending Practitioner; and

c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility;

b. he or she changes attending Practitioners; or

c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;

b. the Covered Person's group plan number;

c. the reason for the admission;

d. the name and location of the Hospital;

e. when the admission occurred; and

f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;

b. the anticipated length of stay; and

c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and

b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:

a. the Covered Person does not request a pre-hospital review; or

b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or

c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or

d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [[Carrier] reduces what it pays for covered Hospital charges **by 50%**], if:

a. [ABC] is not notified of the admission at the times and in the manner described above;

b. the Covered Person does not request a continued stay review; or

c. the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under the Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or

b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under the Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion.] The Covered Person may get the second opinion from [a Practitioner on the list, or from] a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;

b. is not a business associate of the Covered Person's Practitioner; and

c. does not perform the Surgery if it is needed.

[[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].]

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of the Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the Proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [[Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%**], if:

a. the Covered Person does not request a pre-surgical review; or

b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or

c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done; or

d. [ABC] does not confirm the need for Surgery.

Penalties cannot be used to meet the Policy's:

a. Cash Deductible; or

b. Co-Insurance Caps.]

[ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.

b. Benefits for charges incurred for the services and supplies would not otherwise be payable under the Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay

b. spinal cord Injury

c. severe burn over 20% or more of the body

d. multiple injuries due to an accident

e. premature birth

f. CVA or stroke

g. congenital defect which severely impairs a bodily function

h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure

i. terminal illness, with a prognosis of death within 6 months

j. Acquired Immune Deficiency Syndrome (AIDS)

k. chemical dependency

l. mental, nervous and psychoneurotic disorders

m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;

b. the Covered Person's attending Practitioner; and

c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;

b. course of treatment to accomplish the stated objectives;

c. the responsibility of each of the following parties in implementing the plan:

- [DEF]
- attending Practitioner
- Covered Person
- Covered Person's family, if any; and

d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of the Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.]

[CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Treatment Screening Evaluation; and

b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of the Policy. However, the Utilization Review Features will not apply.]]

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in the Policy, unless it is required as a result of an Illness or Injury sustained while covered under the Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances, except as otherwise stated in the Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;

b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or

c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy,*** except as otherwise stated in the Policy.

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in the Policy and this [certificate], or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this [certificate].

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in the Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Covered Person would not have been charged if he or she did not have health care coverage;

d. provided by or in a government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this [certificate's] **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this [certificate] at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this [certificate's] CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this [certificate]:

If a Covered Person elects to continue his or her group health benefits under both this [certificate's] CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

a. Your Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under the Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Policy during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and
b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, You may elect to extend Your 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the qualified continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If You die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Policy, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in the Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue the Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to Your entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Policy ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this [certificate's] **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

If an Employee's Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What the Employee Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

You must pay the subsequent premiums to the Employer, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed insured under the Policy on a regular basis. It includes any amount that Your Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under the Policy on a regular basis. Any modifications made under the Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for You to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Covered Person becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Covered Person becomes covered under another group health benefits plan which contains no limitation or exclusion with respect to any Pre-existing Condition of the Covered Person;

e. with respect to a Covered Person who becomes covered under another group health benefits plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in the Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been insured by the Policy for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give Your Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under the Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an

active Full-Time Employee, insured under the Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay [Carrier] on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date the Policy ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in the Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to Your Employer's Policy. You must contact Your Employer to find out if:

- **Your Employer must allow for a leave of absence under Federal law in which case;**
- **the section applies to You.**

If An Employee's Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your group health benefits insurance will be continued. Dependents' insurance may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date You return to Full-Time work;

b. the end of a total leave period of 12 weeks in any 12 month period;

c. the date on which Your coverage would have ended had You not been on leave; or

d. the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were insured under the Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of the Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health benefits for Your former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under the Policy on the date the group health benefits ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

a. if he or she is eligible for Medicare; or

b. if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health benefits ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health benefits under the Policy ends.

After group health benefits under the Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under the Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under the Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the group health benefits insurance provided by the Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date Group Health Benefits Insurance Ends

Insurance for You and Your Dependents will end on the date You become an HMO member.

Benefits After Group Health Benefits Insurance Ends

When You become an HMO member, the **Extended Health Benefits** section of this [certificate] will not apply to You and Your Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN group health benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS GROUP HEALTH BENEFITS INSURANCE PROVIDED BY THE POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If You elect to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If You request insurance during this period, You and Your Dependents will be insured on the date such period ends.

request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If You request insurance because membership ends for these reasons, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If You request insurance because membership ends for this reason, the date You and Your Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, You and Your Dependents will be Late Enrollees.

request made at any other time

You may request insurance at any time other than that described above. In this case, You and Your Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by the Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in the Policy, regardless of any interruption in such person's insurance under the Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under the Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

Purpose Of This Provision

A Covered Person may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by the Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay part of the premium; or

g. Medicare or other government programs which [Carrier] is allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less for which You pay the entire premium; nor

d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carrier's] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pays less than [Carrier] would otherwise pay, [Carrier] applies only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. You must supply [Carrier] with as much of that information as You can. But if You cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another

insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan has been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under the Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. the Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under the Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

The Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under the Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. The Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

The Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case the Policy will be primary.

If there is a dispute as to which policy is primary, the Policy will pay benefits as if it were primary.

Benefits the Policy will pay if it is primary to PIP or OSAIC.

If the Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of the Policy will apply if:

- the covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits the Policy will pay if it is secondary to PIP or OSAIC.

If the Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the benefits that would have been paid if the Policy had been primary.

Medicare

If the Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

MEDICARE AS SECONDARY PAYOR

IMPORTANT NOTICE

The following sections regarding Medicare may not apply to Your Employer's Policy. You must contact Your Employer to find out if Your Employer is subject to Medicare as Secondary Payor rules.

If Your Employer is subject to such rules, this Medicare as Secondary Payor section applies to You.

If Your Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to You, in which case, Medicare will be the primary health plan and the Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.

The following provisions explain how the Policy's group health benefits interact with the benefits available under Medicare as Secondary Payor rules. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as explained below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the United States Social Security Act, as amended from time to time.

b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to You or Your insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose the Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When The Policy is Primary** section below, for details.

Option (B)—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under the Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When the Policy is primary

When a Medicare eligible chooses the Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by the Policy. Coverage under the Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose the Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of disability.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, Medicare is the primary plan. The Policy is the secondary plan.

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both the Policy and Medicare, the Policy is considered primary. The Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both the Policy and Medicare, Medicare is the primary plan. The Policy is the secondary plan. If a Covered Person is eligible for Medicare on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by the Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under the Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under the Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office

of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require a extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT X
PART 1

EXPLANATION OF BRACKETS—CERTIFICATE FORMS

(PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

1. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].

2. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.

3. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.

4. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the certificate forms.

1. The face page text may be modified to be consistent with a Carrier's methods of certificate personalization. The certificate level data that is illustrated on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the certificate. Carriers may also elect to issue no-name certificates.

2. The term "certificate" may be replaced with certificate booklet, certificate of insurance, employee booklet, booklet certificate, evidence of coverage, or similar titles used to identify the document provided to employees insured under an employer's group policy.

3. Variable amounts appearing in the Schedule of Insurance may be included on the Schedule, or specified on the face page, sticker, or separate schedule, as discussed above.

4. The Payment of Premiums—Grace Period section of the General Provisions may be omitted from the certificate, at the option of the Carrier.

5. Dividend text which appears both on the Face Page and in the General Provisions should only be included by Carriers that could pay dividends. At the option of the carrier, such text may be omitted from the certificate.

6. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.

7. The Payment of Claims provision of the Claims Provisions should include the second or third sentence of the last paragraph, as appropriate.

8. The definition of Reasonable and Customary should only include a reference to the negotiated fee schedule if the Carrier is offering the plan using a Preferred Provider Option or a Point of Service delivery system.

9. The Definition of "You, Your and Yours" may be omitted. If omitted, references throughout the text to You, Your and Yours should be replaced with Employee terminology.

10. The Waiting Period provision of the Employee Coverage provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

11. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

12. The Utilization Review Features provisions may be omitted in their entirety, or only one section, the Required Hospital Stay Review or the Required Pre-Surgical Review section may be omitted. If any portion of Utilization Review Features is to be included, either the text must conform to the text of the standard form, except that the penalty for non-compliance may be adjusted to reflect a different percentage, or to utilize a dollar penalty; or the text must be submitted to the Board and the Department of Insurance for review and approval prior to use, as specified in regulation.

13. The Alternate Treatment Features provisions may be omitted. Carrier may administratively provide for such provisions. If included in the policy, the text must conform to the text of the standard form.

14. The Centers of Excellence Features provisions may be omitted. If included in the policy, the text must conform to the text of the standard form.

(RIDERS)

All text which is enclosed in brackets [ ] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The Appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.

EXHIBIT X
PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].

b. Some areas of variability are noted with brief explanations within the text.

c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.

d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Evidence of Coverage forms.

1. The face page text may be modified to be consistent with a Carrier's methods of Evidence of Coverage personalization. The data reflected on the face page may appear on a separate schedule or sticker, or may be incorporated in the body of the document. Carriers may also elect to use a no-name Evidence of Coverage.

2. The term "Evidence of Coverage" may be replaced with another similar term to adapt to a carrier's typical practice of providing employees with proof of coverage documents.

3. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.

4. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.

5. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.

6. OB/GYNs can be considered Primary Care Physicians.

7. Eligible class references can be removed.

8. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Employer. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.

9. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

10. Small Claims Waiver can be deleted.

11. Transfer of Primary Care Physician can occur according to Carrier administration.

EXHIBIT Y

[Carrier] HMO PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION EVIDENCE OF COVERAGE

[[Carrier] certifies that the Employee named below is entitled to Covered Services and Supplies described in this Evidence of Coverage, as of the effective date shown below, subject to the eligibility and effective date requirements of the Contract.]

[The Contract is an agreement between [Carrier] and the Contract Holder. This Evidence of Coverage is a summary of the Contract Provisions that affect Your Coverage. All Covered Services and Supplies and Non-Covered Services and Supplies are subject to the terms of the Contract.]

CONTRACT HOLDER: [ABC Company]
GROUP CONTRACT NUMBER: [G-12345]
[EMPLOYEE: [John Doe]]
[CERTIFICATE NUMBER: [C-123456]]
EFFECTIVE DATE OF EVIDENCE OF COVERAGE: [January 1, 1994]

[COVERED CLASSES:
[All Employees of the Contract Holder (and its Associated Companies) who permanently reside in the Service Area and are eligible or covered under the Group Care Health Plan.]]

SERVICE AREA: [The State of New Jersey]
AFFILIATED COMPANIES: [DEF Company]

COST OF THE COVERAGE:
[The coverage in this Evidence of Coverage is Contributory Coverage. You will be informed of the amount of Your contribution when You enroll.]

[HMO's Address: [400 Main Street
Chester, New Jersey 00000]

This Evidence of Coverage replaces any older Evidence of Coverage isued to You for the Group Health Care Plan.

[Secretary President]

TABLE OF CONTENTS

Section		Page
I.	SCHEDULE OF SERVICES	
II.	DEFINITIONS	
III.	ELIGIBILITY	
IV.	COVERED SERVICES AND SUPPLIES	
V.	NON-COVERED SERVICES AND SUPPLIES	
VI.	GRIEVANCE PROCEDURE	
VII.	COORDINATION OF BENEFITS AND SERVICES	
VIII.	MEMBER GENERAL PROVISIONS	
IX.	CONTINUATION PROVISIONS	
X.	RIGHT OF RECOVERY	
XI.	EFFECT OF MEDICARE ON THE COVERAGE	

I. SCHEDULE OF SERVICES

THE SERVICES OR SUPPLIES COVERED ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.

[SERVICES	COPAYMENTS[/COINSURANCE]:
HOSPITAL SERVICES:	
INPATIENT	$150 Copayment/day for a maximumum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.
OUTPATIENT	$15 Copayment/visit
DOCTOR SERVICES RECEIVED AT A HOSPITAL:	
INPATIENT	None
OUTPATIENT	$15 Copayment/visit; no Copayment if any other Copayment applies.
EMERGENCY ROOM	$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related Illness or Injury for which the person visited the Emergency Room)
OUTPATIENT SURGERY	$15 Copayment/visit.
HOME HEALTH CARE	Unlimited days, if preapproved.
HOSPICE SERVICES	Unlimited days, if preapproved.
MATERNITY (PRE-NATAL CARE)	$25 Copayment for initial visit only.
MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:	
OUTPATIENT	$15 Copayment/visit maximum 20 visits/Calendar Year.
INPATIENT	$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year. Maximum of 30 days inpatient care/ Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.
PODIATRIC	$15 Copayment/visit (excludes Routine Foot Care).
PRE-ADMISSION TESTING	$15 Copayment/visit.
PRESCRIPTION DRUG	50% Coinsurance [May be substituted by Carrier with $15 Copayment.]
PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES	$15 Copayment/visit.
PRIMARY CARE SERVICES	$15 Copayment/visit.
REHABILITATION SERVICES	Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceeded by a Hospital Inpatient Stay.

SECOND SURGICAL OPINION	$15 Copayment/visit.
SPECIALIST SERVICES	$15 Copayment/visit.
SKILLED NURSING CENTER	Unlimited days, if preapproved.
THERAPY SERVICES	$15 Copayment/visit.
DIAGNOSTIC SERVICES (OUTPATIENT)	$15 Copayment/visit.

NOTE: NO SERVICES OR SUPPLIES WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE ENTIRE EVIDENCE OF COVERAGE CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS EVIDENCE OF COVERAGE CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT THE SERVICES AND SUPPLIES ARE FOR WHICH A MEMBER IS NOT ELIGIBLE.

II. DEFINITIONS

The words shown below have specific meanings when used in this Evidence of Coverage. Please read these definitions carefully. Throughout the Evidence of Coverage, these defined terms appear with their initial letters capitalized. They will help Members understand what services are provided under the Group Health Care Plan.

[**ACTIVELY AT WORK or ACTIVE WORK.** Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires You to go.]

ALCOHOL ABUSE. Abuse of or addiction to alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[**CARE MANAGER.** An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

CONTRACT. The contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier] which defines the terms and conditions under which the [Carrier] agrees [to provide or arrange] health care for the Employer's Employees [or members].

CONTRACT HOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Evidence of Coverage.

Read the entire Evidence of Coverage to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

(a) is furnished mainly to help a Member meet his or her routine daily needs; or

(b) can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

Your:

a. legal spouse;

b. unmarried Dependent child who is under age 19; and

c. unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section.

Your "unmarried Dependent child" includes Your legally adopted child, Your step-child if such step-child depends on You for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is covered by the Group Health Care Plan as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

DEPENDENT'S ELIGIBILITY DATE.

The later of:

a. Your Employee Eligibility Date; or

b. the date the person first becomes a Dependent.

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

(a) radiology, ultrasound, and nuclear medicine;

(b) laboratory and pathology; and

(c) EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION. Our sole right to make a decision or determination.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

(a) designed and able to withstand repeated use;

(b) used primarily and customarily for a medical purpose;

(c) is generally not useful to a Member in the absence of an Illness or Injury; and

(d) suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under the Group Health Care Plan for a Member.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of the Group Health Care Plan's conditions of eligibility.

EMPLOYEE ELIGIBILITY DATE.

a. the date of employment; or

b. the day after any applicable waiting period ends.

EMPLOYER. [ABC Company].

EXPERIMENTAL OR INVESTIGATIONAL.

Services or supplies which We Determine are:

(a) not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or

(b) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or

(c) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular

diagnosis or treatment of a Member's particular condition, as explained below.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia:

I. The American Medical Association Drug Evaluations;

II. The American Hospital Formulary Service Drug Information; or

III. The United States Pharmacopeia Drug Information

recognize the usage as appropriate medical treatment. As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature. A medical device, drug, or biological product that meets the above tests will not be considered Experimental or Investigational.

In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered Experimental or Investigational.

2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

GROUP HEALTH CARE PLAN. The plan of health care coverage described in this Evidence of Coverage which a Contract Holder is providing for its Employees [or members].

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

HOME HEALTH AGENCY. A Provider which provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A Provider which provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be approved for its stated purpose by Medicare; or

(b) be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited as a hospital by the Joint Commission; or

(b) be approved as a hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member. A Mental and Nervous Condition is not an Illness.

INITIAL DEPENDENT. Those eligible Dependents You have at the time You first become eligible for Employee coverage. If at the time You do not have any eligible Dependents, but later acquire them, the first eligible Dependents You acquire are Your Initial Dependents.

INJURY. Damage to a Member's body due to accident, and all complications arising from that damage.

INPATIENT. Member if physically confined as a registered bed patient in a Hospital or other recognized heath care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

LATE ENROLLEE. An eligible Employee or Dependent who requests enrollment under the Group Health Care Plan more than [30] days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections appearing on later pages.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Examples of Medical Emergencies include, but are not limited to, heart attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

(a) necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

(b) provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;

(c) in accordance with generally accepted medical practice;

(d) not for a Member's convenience;

(e) the most appropriate level of medical care that a Member needs; and

(f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that a Non-participating Provider prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Contract (includes Subscriber/covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

(a) accredited for its stated purpose by the Joint Commission;

(b) approved for its stated purpose by Medicare; or

(c) accredited or licensed by the State of New Jersey to provide mental health services.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders,

schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent You acquire after You already have coverage in force for Initial Dependents.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, are included in the list of Non-covered Services and Supplies, or which exceed any of the limitations shown in this Evidence of Coverage.

NON- [NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and

(b) provides medical services which are within the scope of the nurse's license or certificate and are covered by the Group Health Care Plan.

OUTPATIENT. Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PRACTITIONER. A medical practitioner who:

(a) is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

(b) provides medical services which are within the scope of the practitioner's license or certificate and which are covered by the Group Health Care Plan.

[PRE-EXISTING CONDITION. An Illness or Injury or Mental or Nervous Condition which manifests itself in the six months before a Member's coverage under the Group Health Care Plan starts, and for which:

(a) a Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or

(b) an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

See the Non-Covered Services and Supplies section for details on how the Group Health Care Plan limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for pre- and post-natal care, birth and treatment of the diseases and hygiene of females,] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE AND CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary under the Group Health Care Plan. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician in conformance with Our policies and procedures that directs a Member to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or

(b) be approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA. A geographic area We define by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or sub-specialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for routine pre- and post-natal care, birth and treatment of the diseases and hygiene of females)].

SUBSCRIBER. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

(a) be accredited for its stated purpose by the Joint Commission; or

(b) be approved for its stated purpose by Medicare.

SURGERY.

(a) The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;

(b) the correction of fractures and dislocations; or

(c) pre-operative and post-operative care.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment, resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Evidence of Coverage, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[WE, US, OUR. [Carrier].

YOU, YOUR AND YOURS. The Employee.]

III. ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Group Health Care Plan, all of the Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

We will treat partners, proprietors and independent contractors like Employees if they meet the Group Health Care Plan's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not cover You unless You are an Actively at Work Full-Time Employee.

Enrollment Requirement

We will not cover You until You enroll and agree to make the required payments, if any. If You do this within [30] days of Your Employee Eligibility Date, coverage will start on the Your Employee Eligibility Date.

If You enroll and agree to make the required payments, if any:

a. more than [30] days after the Your Employee Eligibility Date; or

b. after You previously had coverage which ended because You failed to make a required payment,

We will consider You to be a Late Enrollee. Late Enrollees are subject to this Group Health Plan's Pre-Existing Conditions limitation.

However, if You initially waived coverage under the Group Health Care Plan, and You stated at that time that such waiver was because You were covered under another group plan, and You now elect to enroll under this Group Health Care Plan, We will not consider You to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, You must enroll under this Group Health Care Plan within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date You become eligible.

[The Waiting Period

The Group Health Care Plan has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Group Health Care Plan from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for coverage under the Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Group Health Care Plan from the day after Employees complete [6] months of continuous Full-Time service with the Employer.]

Multiple Employment

If You work for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat You as if only one firm employs You. And You will not have multiple coverage under the Group Health Care Plan.

When Employee Coverage Starts

You must be Actively at Work, and working Your regular number of hours, on the date Your coverage is scheduled to start. And You must have met all the conditions of eligibility which apply to You. If You are not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of Your coverage until You return to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But Your coverage will start on that date if You were Actively at Work, and working Your regular number of hours, on Your last regularly scheduled work day.

You must elect to enroll and agree to make the required payments if any, within [30] days of the Employee Eligibility Date. If You do this within [30] days of the Employee Eligibility Date, Your coverage is scheduled to start on Your Employee Eligibility Date. Your Employee Eligibility Date is the scheduled Effective Date of Your coverage.

When Employee Coverage Ends

Your coverage under the Group Health Care Plan will end on the first of the following dates:

a. You cease to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.

b. You stop being an eligible Employee under the Group Health Care Plan.

c. the date this Group Health Care Plan ends, [or is discontinued for a class of Employees to which You belong.]

d. for which required payments are not made for You.

e. You move Your permanent residence outside the Service Area.

Also, You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. This Evidence of Coverage's continuation provisions explain these situations. Read these provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

Your eligible Dependents are:

a. Your legal spouse;

b. Your unmarried Dependent children who are under age 19; and

c. Your unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be defined by the accredited school. We can require periodic proof of a Dependent child's status as a full-time student.

Adopted Children and Step-Children

Your "unmarried Dependent children" include Your legally adopted children, if they depend on You for most of their support and maintenance, Your step-children and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:
a. covered by the Group Health Care Plan as an Employee or
b. on active duty in the armed forces of any country.

Incapacitated Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Group Health Care Plan, such a child may stay eligible for Dependent health benefits past this Group Health Care Plan's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:
a. the child's condition started before he or she reached this Group Health Care Plan's age limit; and
b. the child depends on You for most of his or her support and maintenance.

But, for the child to stay eligible, You must send Us written proof that the child is handicapped and depends on You for most support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when Yours does.

Enrollment Requirement

You must enroll Your eligible Dependents in order for them to be covered under the Group Health Care Plan. [Carrier] considers an eligible Dependent to be a Late Enrollee, if You:
a. enroll a Dependent more than [30] days after the Dependent's Eligibility Date;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible Dependents who You have not elected to enroll; or
c. in the case of a Newly Acquired Dependent, have other eligible Dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Group Health Care Plan's Pre-Existing Conditions limitations section, if any applies.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your Dependents will be considered Late Enrollees when their coverage begins again.

However, if You previously waived coverage for Your spouse or eligible Dependent children under the Group Health Care Plan and stated at that time that such waiver was because they were covered under another group plan, and You now elect to enroll them in this Group Health Care Plan, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:
a. termination of employment;
b. divorce;
c. death of Your spouse; or
d. termination of the other plan's coverage.

But, Your spouse or eligible Dependent children must be enrolled by You within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date one of the above events occurs.

And, [Carrier] will not consider Your spouse or eligible Dependent children for which You initially waived coverage under the Group Health Care Plan, to be a Late Enrollee, if:
a. You are under legal obligation to provide coverage due to a court order; and
b. Your spouse or eligible Dependent children are enrolled by You within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

When Dependent Coverage Starts

In order for Your dependent coverage to begin You must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of the Group Health Care Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents.

If You do this within [30] days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a. the Dependent's Eligibility Date, or
b. the date You become covered for Employee coverage.

If You do this more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee, the coverage is scheduled to start on the later of:
a. the date You sign the enrollment form; or
b. the date You become covered for Employee coverage.

Once You have dependent coverage for Initial Dependents, You must notify Us of a Newly Acquired Dependent within the [30] days after the Dependent's Eligibility Date. If You do not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:
a. the date You notify [Carrier], or
b. the Dependent's Eligbility Date for the Newly Acquired Dependent.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date Your Dependent health coverage would otherwise start, [Carrier] will postpone the Effective Date of such coverage until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

Newborn Children

We will cover Your newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:
a. If You are already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]
b. If You are not covered for Dependent child coverage on the date the child is born, You must:
- make written request to enroll the newborn child.

If the request is not made within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's coverage under the Group Health Care Plan will end on the first of the following dates:
a. Your coverage ends;
b. the date the Group Health Care Plan ends;
c. the date Dependent coverage is dropped from the Group Health Care Plan for all Employees eligible for such coverage;
d. At 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted policies.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under the Group Health Care Plan:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.

(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use any identification card We issue to the Member.

(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under the Group Health Care Plan. This condition is subject to the provisions of the section Incontestability of Coverage.

(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under the Group Health Care Plan.

(5) **Misconduct:** The Member abuses the system, including, but not limited to: theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.

(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits and Services Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under the Group Health Care Plan immediately if termination is occuring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and

(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

IV. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

(a) **OUTPATIENT SERVICES.** The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:

1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
2. **Home visits** by a Member's Primary Care Physician.
3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
7. **Infertility Services** except where specifically excluded in this Evidence of Coverage.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to the functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
10. **Prescription Drugs and insulin syringes and insulin needles** when obtained through a Participating Provider.

(b) **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician. Services include, but are not limited to, the following:

1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
2. Anesthesia
3. Cardiology
4. Endocrinology
[5. Gynecology and Obstetrics]
6. Internal Medicine
7. Neurology
8. Oncology
9. Ophthalmology
10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
11. Orthopedics
12. Otolaryngology
13. Pathology
14. Pediatrics
15. Podiatry
16. Pulmonology
17. Radiology (except dental x-rays, unless related to Covered Services)
18. Surgery
19. Urology

(c) **INPATIENT HOSPICE, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center Services and Supplies are limited to those which constitute Skilled Nursing Care and Hospice Services are subject to Our pre-approval:

1. Semi-private room and board accommodations
2. Private accommodations [will be provided only when approved in advance by Us]. If a Member occupies a private room without such certification Member shall be directly liable to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center for the difference between payment by Us to the Hospice, Hospital, Rehabilitation Center or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the Participating Hospice, Participating Hospital, Participating Rehabilitation Center or Participating Skilled Nursing Center and the private room rate.
3. General nursing care
4. Use of intensive or special care facilities
5. X-ray examinations including CAT scans but not dental x-rays
6. Use of operating room and related facilities
7. Magnetic resonance imaging "MRI"
8. Drugs, medications, biologicals
9. Cardiography/Encephalography
10. Laboratory testing and services
11. Pre- and post-operative care
12. Special tests
13. Nuclear medicine
14. Therapy Services
15. Oxygen and oxygen therapy
16. Anesthesia and anesthesia services
17. Blood, blood products and blood processing
18. Intravenous injections and solutions
19. Surgical, medical and obstetrical services
20. Private duty nursing only when approved in advance by Us
21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
22. Allogenic bone marrow transplants
23. Autologous bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich) and Breast Cancer, when approved in advance by Us, if the Member is participating in a National Cancer Institute sponsored clinical trial.

(d) **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health Center] upon prior written referral by a Member's Primary Care Physician.

1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.

2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

Chemical Dependency Admissions Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.

3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

(e) **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.

2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:

a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
   1. heart attacks
   2. strokes
   3. convulsions
   4. serious burns
   5. obvious bone fractures
   6. wounds requiring sutures
   7. poisoning
   8. loss of consciousness

   A near-term delivery is not a Medical Emergency.

b. The service rendered is provided as a Covered Service or Supply under the Group Health Care Plan and is not a service or supply which is normally treated on a non-emergency basis; and

c. We and a Member's Primary Care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.

3. In the event Members are hospitalized in a Non-participating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Non-participating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided upon prior written referral to a Participating Provider.

4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Members shall be responsible for payment.

5. The Copayment for an emergency room visit will be credited toward the Hospital Inpatient Copayment if Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

(f) **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.

1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.

2. Chelation Therapy, Chemotherapy Treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

(g) **HOME HEALTH SERVICES.** The following Services are covered when rendered by a Participating Provider including, but not limited to, a Participating Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.

1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.

2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.

3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.

4. Therapy Services as set forth above.

5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician, Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members, inpatient care; counseling and emotional support; and other Home Health benefits listed above.

Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate care.

V. NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE *NOT* COVERED SERVICES UNDER THE GROUP HEALTH CARE PLAN.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Evidence of Coverage, unless it is required as a result of an Illness or Injury sustained while covered under the Group Health Care Plan or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Evidence of Coverage.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;

b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or

c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of Your **family:** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, in vitro fertilization,

in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to **Hearing aids** and hearing examinations to determine the need for hearing aids or the need to adjust them.

Services or supplies related to **Herbal medicine.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Evidence of Coverage.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Evidence of Coverage, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except insulin needles and insulin syringes.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious official or practitioner.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until Members have been covered by this Group Health Care Plan for six months. See the "Definitions" section of this Evidence of Coverage for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for A Member's Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Group Health Care Plan started, i.e., there is no intervening lapse in coverage.]

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Evidence of Coverage.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care.**

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;

b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;

c. for which a Member would not have been charged if he or she did not have health care coverage;

d. provided by or in a Government Hospital unless the services are for treatment:

- of a non-service Medical Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Evidence of Coverage.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

VI. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VII. COORDINATION OF BENEFITS AND SERVICES

COORDINATION OF BENEFITS AND SERVICES

Purpose Of This Provision

A Member may be covered for health benefits or services by more than one plan. For instance, he or she may be covered by this Group Health Care Plan as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays or provides. We do this so the Member does not collect more than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;

b. group hospital or surgical plans, or other service or prepayment plans on a group basis;

c. union welfare plans, Employer plan, Employee benefits plans, trusted labor and management plans, or other plans for members of a group;

d. programs or coverages required by law;

e. group or group-type hospital indemnity benefits which exceed $250.00 per day;

f. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employer pays part of the premium;

g. Medicare or other government programs which We are allowed to coordinate with by law.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;

b. school accident type coverages written on either a blanket, group, or franchise basis;

c. group or group-type hospital indemnity benefits of $250.00 per day or less which the Employee pays the entire premium; nor

d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"Subscriber", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits or services.

"Dependent" means a person who is covered by a plan for health benefits or services, but not as a Subscriber.

"Allowable expense" means any necessary, reasonable, and usual item of expense or service for health care incurred by a Subscriber or Dependent under either this Group Health Care Plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a Subscriber's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the Subscriber or Dependent elects to have health services provided outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a Subscriber or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a Subscriber or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first or provides services, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays or provides services more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays or provides services first are as follows:

a. A plan that covers a person as a Subscriber pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a Subscriber:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a Subscriber whose birthday falls later in the Calendar Year pays second. The Subscriber's year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits or services.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays or provides services first when the person is a Dependent of a Subscriber.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays or provides services first.
- If there is no such court order, then the plan of the natural parent with custody pays or provides services before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays or provides services before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits and services, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan or services that should have been provided by this plan have been made by or provided another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount or equivalent value of services. And if We pay out more than We should have, We have the right to recover the excess payment.

[Small Claims Waiver

We do not coordinate claims or equivalent services of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

SERVICES FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's coverage under the Group Health Care Plan when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense or eligible services by:

a. this Group Health Care Plan;

b. PIP; or

c. OSAIC.

"Eligible Services" means that of service provided for treatment of an Injury which is covered under this Group Health Care Plan without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage

This Group Health Care Plan provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Group Health Care Plan. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Group Health Care Plan may be primary for one Member, but not for another if the person has a separate automobile policy and has made different selections regarding primacy of health coverage.

This Group Health Care Plan is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Group Health Care Plan will be primary.

If there is a dispute as to which policy is primary, this Group Health Care Plan will pay benefits or provide services as if it were primary.

Services this Group Health Care Plan will provide if it is primary to PIP or OSAIC.

If this Group Health Care Plan is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS AND SERVICES** section of this Group Health Care Plan will apply if:

- the Member is insured or covered for services under more than one insurance plan; and
- such insurance plans or HMO Contracts are primary to automobile insurance coverage.

Benefits this Group Health Care Plan will pay if it is secondary to PIP or OSAIC.

If this Group Health Care Plan is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or

b. the equivalent value of services if this Group Health Care Plan had been primary.

VIII. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Group Health Care Plan is valid unless We consent thereto.

CONFIDENTIALITY

Information contained in the medical record of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Group Health Care Plan or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Group Health Care Plan.

CONVERSION PRIVILEGE

If a Subscriber's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

GOVERNING LAW

This entire Group Health Care Plan is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Group Health Care Plan is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Group Health Care Plan, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Group Health Care Plan, the holder of the card must be a Member on whose behalf all applicable premium charges under this Group Health Care Plan have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Group Health Care Plan shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Group Health Care Plan shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including, but not limited to, major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Group Health Care Plan, or similar causes, the rendition of medical or hospital benefits or other services provided under this Group Health Care Plan is delayed or rendered impractical. We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Group Health Care Plan shall be used in contesting the validity of his or her coverage or in deny benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If the Contract replaces the contract of another insurer, We may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from the Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.

2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Group Health Care Plan.

3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.

4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION OF SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Group Health Care Plan only when Medically Necessary and Appropriate. We may determine whether any service or supply provided [or arranged] under the Group Health Care Plan was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [Our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Group Health Care Plan that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Group Health Care Plan.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: To the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide services and supplies to the extent stated in the Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Group Health Care Plan.

We reserve the right to modify or replace an erroneously issued Evidence of Coverage.

Information in a Member's application may not be used by Us to void the Contract or in any legal action unless the application or a duplicate of it is attached to the Contract or has been mailed to a Member.

CONTRACT INTERPRETATION

We shall administer Group Health Care Plan in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including, but not limited to, Specialist services) if a Member has not been referred by his or her Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under the Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Group Health Care Plan subject to all applicable confidentiality requirements as defined in this Evidence of Coverage. By accepting coverage under this Group Health Care Plan, Subscriber, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to the Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of a Member's records by Us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When You first obtain this coverage, You and each of Your covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [Physician or Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician-patient relationship becomes unacceptable. The Member can select another Primary Care Physician from Our [Physician or Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under the Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If You fail to pay the cost of Dependent coverage, Your Dependent coverage will end. It will end on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he or she attains the Group Health Care Plan's age limit, or marries, or when a stepchild is no longer dependent on You for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when Your coverage ends.

Read this Evidence of Coverage carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when A Member needs treatment for one of these conditions.]

IX. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Group Health Care Plan's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Group Health Care Plan at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a Member is eligible to continue his or her group health benefits under both this Group Health Care Plan's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Group Health Care Plan:

If a Member elects to continue his or her group health benefits under both this Group Health Care Plan's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. You must contact Your Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;
b. the section applies to You.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Group Health Care Plan as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under the Group Health Care Plan during a continuation provided by this section is not a qualified continuee.

If Your Group Health Benefits Ends

If Your group health benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if:

a. You were not terminated due to gross misconduct; and

b. You are not entitled to Medicare.

The continuation:

a. may cover You and any other qualified continuee; and

b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and

b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from You by the Employer during this extra 11 month continuation period.

If You Die While Covered

If You die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If Your Marriage Ends

If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in the Group Health Care Plan, other than Your coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to Your termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or

b. You become entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of You from Your spouse; or

b. the loss of dependent eligibility, as defined in this Group Health Care Plan, of a covered Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his or her right to continue the Group Health Care Plan's group health benefits;

b. the monthly premium he or she must pay to continue such benefits; and

c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or

b. the date a qualified continuee notifies the Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent's eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or

b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Group Health Care Plan on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

c. with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

e. the date the Contract ends;

f. the end of the period for which the last premium payment is made;

g. the date he or she becomes covered under any other Group Health Care Plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;

h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this Evidence of Coverage's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If Your Group Benefits End

If Your health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, You may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At Your option, You may elect to continue health coverage for any of Your then covered Dependents whose coverage would otherwise end at this time. In order to continue health coverage for Your Dependents, You must elect to continue health coverage for Yourself.

What You Must Do

To continue Your health coverage, You must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. You must also pay the first month's premium. The first premium payment must be made within 30 days of the date You elect continuation.

The subsequent premiums must be paid to the Employer, by You, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had You stayed covered under this Group Health Care Plan on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If You fail to give the Employer notice that You elect to continue, or fail to make any premium payment in a timely manner, You waive Your continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

Your continued coverage will be identical to the coverage You had when covered under this Group Health Care Plan on a regular basis. Any modifications made under this Group Health Care Plan will apply to similarly situated continuees. We do not ask for evidence of good health in order for You to continue.

When Continuation Ends

A Member's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;

b. the date the Member becomes eligible for Medicare;

c. the end of the period for which the last premium payment is made;

d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;

e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;

f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or

g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Group Health Care Plan.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You are Totally Disabled

If You are Totally Disabled and Your group health benefits end because Your active employment or membership in an eligible class ends due to that disability, You can elect to continue Your group health benefits. But You must have been covered by this Group Health Care Plan for at least three months immediately prior to the date Your group health benefits ends. The continuation can cover You, and at Your option, Your then covered Dependents.

How And When To Continue Coverage

To continue group health benefits, You must give the Employer written notice that You elect to continue such benefits. And You must pay the first month's premium. This must be done within 31 days of the date Your coverage under this Group Health Care Plan would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium You must pay will be the total rate charged for an active Full-Time Employee, covered under this Group Health Care Plan on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider Your failure to give notice or to pay any required premium as a waiver of Your continuation rights.

If the Employer fails, after the timely receipt of Your payment, to pay Us on Your behalf, thereby causing Your coverage to end; then such Employer will be liable for Your benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if You stop paying.

b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;

c. the date this Group Health Care Plan ends or is amended to end for the class of Employees to which You belonged; or

d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Group Health Care Plan.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence uner Federal law and, therefore
- the section applies to You.

If Your Group Health Coverage Ends

Group health coverage may end for You because You cease Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow You to care for a sick family member or after the birth or adoption of a child. If so, Your medical care coverage will be continued. Dependents' coverage may also be continued. You will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of:

a. the date You return to Full-Time work

b. the end of a total period of 12 weeks in any 12 month period, or

c. the date on which Your coverage would have ended had You not been on leave.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If You die, any of Your Dependents who were covered under this Group Health Care Plan may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of Your death; or

b. the date the Dependent is no longer eligible under the terms of this Group Health Care Plan.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF YOUR MARRIAGE ENDS

If Your marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual policy during the conversion period. The former spouse may cover under his or her individual policy any of his or her Dependent children who were covered under this Group Health Care Plan on the date the group health coverage ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:
- unless he or she has been insured under this Group Health Care Plan for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be overinsured; or
- [• if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if overinsurance exists using Our standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of good health will not be required.

THE CONVERTED CONTRACT

The individual policy will provide the medical benefits that We are required to offer. The individual policy will take effect on the day after group health coverage under this Group Health Care Plan ends.

After group health coverage under this Group Health Care Plan ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Group Health Care Plan. If so, benefits to be paid under the individual policy will be reduced by the amount paid or the reasonable cash value of services provided under this Group Health Care Plan.

X. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us under this Group Health Care Plan prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Group health Care Plan or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

XII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS ARE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.

"Medicare means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The coverage for such Member will continue only while the Member is meeting the following conditions:

(1) In the case of an Employee, the Employee is not retired.

(2) In the case of a Dependent, the Member is the Dependent of an Employee who meets condition (1) above.

(3) The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.

For a Member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

(1) The Member, if eligible, has enrolled in Parts A and B of Medicare.

(2) The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. SERVICES AND SUPPLIES.

The services and supplies of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

EXHIBIT Z
PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD/MAIL)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled. "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

• for Generic Drugs	NONE
• for Brand Name Drugs	$5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Pharmacy or by a Participating Mail Order Pharmacy; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;

b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and

c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE (CARD)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs $ 5.00
- for Brand Name Drugs $10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Pharmacy; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses; and

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:

- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:

- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:

- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE (MAIL)

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness or Injury which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse under the Rider for Prescription Drug Insurance.

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Covered Person can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Mail Order Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);

b. dispensed by a Participating Mail Order Pharmacy for take-home use; and

c. needed to treat an Illness or Injury or Mental and Nervous Conditions and Substance Abuse.

Such charges will not include charges made for more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and

b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.

b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.

e. Charges for refills dispensed after one year from the original date of the prescription.

f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.

g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

m. Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

n. Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

o. Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

p. Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

q. Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT Z
PART 4

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

[Policyholder:

Group Policy No.

Effective Date:]

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[Carrier] covers drugs to treat an Illness, Injury, or Mental and Nervous Conditions and Substance Abuse which require a Practitioner's prescription. But [Carrier] only covers drugs which are:

a. approved for treatment of the Covered Person's Illness, Injury or Mental and Nervous Conditions and Substance Abuse by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information;
3. The United States Pharmacopeia Drug Information; or

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will [Carrier] pay for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

[Carrier] does cover drugs to treat Mental and Nervous Conditions and Substance Abuse as part of the Prescription Drugs Covered Charge. Drugs for such treatment are not covered under the Rider for Mental and Nervous Conditions and Substance Abuse Benefits.

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following:

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and precertifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous conditions and Substance Abuse. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment **must** be reviewed by [XYZ] **before** it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred Provider.

In both emergency and non-emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a Provider.

For Inpatient services certified as medically or clinically necessary by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified as medically or clinically necessary by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of [$150] for each day of Inpatient care up to a maximum of [$750] per confinement, subject to a maximum of [$1,500] Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15.] to the [XYZ] referred Provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a. 30 days of Inpatient care per Calendar Year; and

b. 20 Outpatient visits per Calendar Year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

As a penalty for non-compliance with pre-certification requirements, [Carrier] will not pay for the care and treatment of Mental and Nervous Conditions and Substance Abuse. Such penalty will be applied if:

a. the Covered Person does not request a review in the times and manner described above;

b. the Covered Person's treatment does not comply with the treatment plan;

c. the Covered Person goes to a Provider whose services were not referred by [XYZ]; or

d. [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].]

This rider is part of the [certificate]. Except as stated above, nothing in this rider changes or affects any other terms of the Policy or the [certificate].

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 1

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD/MAIL)

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:

• for Generic Drugs	$ 5.00
• for Brand Name Drugs	$10.00

The Co-Payment for each prescription or refill which is obtained through the Mail-Order Program is:

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug or a 30 day supply of any other Prescription Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 2

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE (CARD)

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury by the Food and Drug Administration;
b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:
   1. The American Medical Association Drug Evaluations;
   2. The American Hospital Formulary Service Drug Information; or
   3. The United States Pharmacopeia Drug Information.
c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or
b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin, insulin needles and insulin syringes; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Group Health Plan provides

any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

- for Generic Drugs $ 5.00
- for Brand Name Drugs $10.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Pharmacy; and
c. needed to treat an Illness or Injury.

Such prescription or refill will not include a prescription or refill that is more than amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

EXHIBIT AA
PART 3

EVIDENCE OF COVERAGE RIDER FOR PRESCRIPTION DRUG COVERAGE **(MAIL)**

Contract Holder:

Group Contract No.

Effective Date:

The **Prescription Drug** section of the **COVERED SERVICES AND SUPPLIES** section of the **HMO EVIDENCE OF COVERAGE** is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are:

a. approved for treatment of the Member's Illness or Injury or Mental or Nervous Condition by the Food and Drug Administration;

b. approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Member's and recognized as appropriate medical treatment for the Member's diagnosis or condition in one or more of the following established reference compendia:

1. The American Medical Association Drug Evaluations;
2. The American Hospital Formulary Service Drug Information; or
3. The United States Pharmacopeia Drug Information.

c. supported by the preponderance of evidence that exists in clinical review studies that are reported in major peer-reviewed medical literature or review articles that are reported in major peer-reviewed medical literature.

In no event will We provide [or arrange] for:

a. drugs labeled: "Caution—Limited by Federal Law to Investigational Use"; or

b. any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; and

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program under which a Member can obtain Prescription Drugs from a Participating Mail Order Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of chronic medical conditions.

Participating Mail Order Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement, that is equipped to provide Prescription Drugs through the mail.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Member must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Mail Order Pharmacy. The Co-Payment must be paid before the Group Health Plan provides any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Co-Payment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Group Health Plan.

COVERED DRUGS

The Group Health Plan only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);
b. dispensed by a Participating Mail Order Pharmacy; and
c. needed to treat an Illness or Injury or Mental or Nervous Condition.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance Drug, or a 30 day supply of any other Prescription Drug; and

b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription Drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use"; or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:

- a Hospital
- a rest home
- a sanitarium
- a Skilled Nursing Center
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use except for insulin use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs used in connection with baldness.

o. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

p. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

q. Drugs dispensed to a Member while on active duty in any armed force.

r. Drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

s. Drugs needed due to an on-the-job or job-related Injury or Illness or Mental or Nervous Condition; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Evidence of Coverage. Except as stated above, nothing in this rider changes or affects any other terms of the Group Health Plan.

[Carrier should insert Standard Rider Closure.]

(a)

DIVISION OF THE NEW JERSEY REAL ESTATE COMMISSION

Notice of Extension of Comment Periods

Qualifications for Licensing; Broker and Broker-Salesperson

Educational Requirements for Salespersons and Brokers in Making Application for Licensure Examination

Prelicensure Schools and Real Estate Instructors; Requirements

Expediting of Licensing Issuance and Transfer Procedures

Proposed Amendments: N.J.A.C. 11:5-1.3, 1.10, 1.27, 1.28 and 1.31

Take notice that the New Jersey Real Estate Commission is extending the public comment period for the above-referenced five notices of proposal, published in the November 1, 1993 New Jersey Register at 25 N.J.R. 4849(b), 4851(a), 4852(a), 4855(a) and 4858(a), respectively, until December 10, 1993.

Submit written comments by December 10, 1993 to:
Robert J. Melillo
Special Assistant to the Director
New Jersey Real Estate Commission
CN-328
Trenton, New Jersey 08625-0328

LAW AND PUBLIC SAFETY

(b)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF MEDICAL EXAMINERS

Limited Licenses: Physician Assistants

Proposed New Rules: N.J.A.C. 13:35-2B
Proposed Repeal: N.J.A.C. 13:35-6.14

Authorized By: State Board of Medical Examiners, Charles A. Janousek, Executive Director.
Authority: N.J.S.A. 45:9-27.26 and 27.28.
Proposal Number: PRN 1993-620.

Submit written comments by December 15, 1993 to:
Marianne Kehoe, Executive Director
Physician Assistant Advisory Committee
Post Office Box 45031
Newark, New Jersey 07101

The agency proposal follows:

Summary

The State Board of Medical Examiners is proposing a new subchapter entitled "Limited Licenses: Physician Assistants," to be codified at N.J.A.C. 13:35-2B in order to implement the provisions of the Physician Assistant Licensing Act, P.L.1991, c.378, as amended by P.L.1992, c.102 (N.J.S.A. 45:9-27.10 et seq., the "Act"). The Act established the Physician Assistant Advisory Committee within the State Board of Medical Examiners and provided the Board with authority to promulgate regulations to effectuate the purposes of the Act.

The Board is also proposing to repeal N.J.A.C. 13:35-6.14, which permits physicians practicing in pilot program institutional settings to participate in a program pursuant to which they may delegate limited tasks to unlicensed physician assistants. This section is proposed for repeal because the individuals employed in these limited settings—as well as all individuals practicing or representing themselves as a physician assistant in any other health care setting—are required to be licensed pursuant to the Act and will be subject to the proposed new rules implementing the Act.

The proposed subchapter covers practice requirements, scope of practice, eligibility for licensure, and various other licensing, educational, supervisory, recordkeeping and medical prescription requirements relating to physician assistants.

N.J.A.C. 13:35-2B.1 sets forth the purpose and scope of the proposed rules, and N.J.A.C. 13:35-2B.2 defines relevant terms. Statutory practice requirements are detailed in N.J.A.C. 13:35-2B.3.

N.J.A.C. 13:35-2B.4 establishes the physician assistant's scope of practice. Subsection (a) identifies 12 procedures that licensees may perform on a discretionary and routine basis. While the first half-dozen of these procedures are those identified in P.L.1992, c.102, in accordance with N.J.S.A. 45:9-27.24 the Board has identified additional procedures which are now safely being performed by the physician assistant on a routine and discretionary basis. Subsection (b) identifies the procedures which, by statute, the physician assistant is permitted to perform only in response to a direct order from a supervising physician. Here, too, additional procedures are identified which are within the training and experience of both the supervising physician and the physician assistant and so are appropriate for inclusion in the scope of practice. Additional practice areas suitable for performance by the physician assistant may be approved by the Board at a later date through the administrative process.

Licensing and educational requirements are set forth in N.J.A.C. 13:35-2B.5. N.J.A.C. 13:35-2B.6 sets forth the citation to the statute defining grounds for refusal to issue a license or for license suspension and revocation. Continuing education requirements—40 credit hours biennially—are detailed in N.J.A.C. 13:35-2B.7 through 2B.9.

N.J.A.C. 13:35-2B.10 defines supervision standards, including the supervisory ratios that must be adhered to in order to guarantee high professional standards. Those ratios are no more than two physician assistants to one physician in a private practice setting and no more than four physician assistants to one physician in an inpatient setting.

The other two areas covered by this proposed subchapter are recordkeeping and the requirements for issuing prescriptions for medications, as set forth in N.J.A.C. 13:35-2B.11 and 2B.12. In each case, the rules being proposed are consistent with statutory requirements as well as with regulations established by the Board of Medical Examiners and other professional health care boards.

Social Impact

This proposed subchapter and the proposed repeal will have a significant and advantageous social impact on the general public, which will benefit by having physician assistants available in all health care settings to perform procedures that might otherwise be delayed, either until a physician is free of other tasks or because no physician is on-site. In the first instance, the resulting staffing flexibility should also allow physician assistants to offer certain services that physicians cannot offer as readily due to their other considerable professional obligations. In the second instance, physician assistants will be on hand to provide competent medical help, especially in medically underserved areas such as the state's inner-cities and rural areas.

Meanwhile, the educational, licensing, practicing, supervisory, and recordkeeping requirements will help to safeguard the public's interest by seeking to ensure that physician assistants are properly qualified and operating in circumstances appropriate to their abilities. Particularly noteworthy are the supervisory requirements, whereby certain ratios are established that will at once provide expanded opportunities for physician assistant care of patients while guaranteeing adequate oversight of physician assistants by licensed physicians.

Economic Impact

One of the original goals of licensing physician assistants was to lower medical costs by permitting fairly routine medical procedures to be performed by assistants at less cost. The proposed repeal and new rules will allow New Jersey to join the ranks of other states that offer consumers in all health care settings the favorable economic impact that physician assistant licensing is expected to provide.

The new rules will also have an economic impact on physician assistants because of the costs that will be involved in meeting the requirement for 40 continuing education credit hours in category I courses in order to qualify for a biennial license renewal.

Physicians who employ physician assistants in their practices may realize the economic benefit of the additional services they may be able to offer to the patient, while hospitals may be expected to save on staffing costs.

Regulatory Flexibility Analysis

The Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., requires the Board to give a description of the types and an estimate of the number of small businesses to which the proposed repeal and new rules will apply. N.J.A.C. 13:35-6.14 provides for the establishment of physician assistant pilot programs at institutional settings, each of which employs more than one hundred full-time employees. Accordingly, a regulatory flexibility analysis with regard to the repeal of this section is not necessary. If, for the purposes of the Act, individual practicing physician assistants are deemed to be "small businesses," the following analysis applies:

The Board anticipates licensing approximately 250 individuals as physician assistants during its first biennial registration period. The proposed new rules will involve a real but not unduly burdensome amount of reporting and recordkeeping, for a variety of reasons. First, physician assistants will be required to notify the Board of any change in employment or supervisor within 10 days of the change.

Additional recordkeeping requirements involve the need to make contemporaneous, permanent entries into professional treatment records which shall accurately reflect the treatment or services rendered, and to garner the necessary information whenever completing a patient's prescription for medication. The new rules require no initial capital costs or the retention of professional services. Compliance costs include the costs of obtaining 40 credit hours of continuing education biennially. Again, all of these requirements are customary and need to be applied throughout the profession to maintain uniform standards. Therefore, the rules provide no exemption based upon business size.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 13:35-6.14.

Full text of the proposed new rules follows:

SUBCHAPTER 2B. LIMITED LICENSES: PHYSICIAN ASSISTANTS

13:35-2B.1 Purpose and scope

(a) The rules in this subchapter implement the provisions of the Physician Assistant Licensing Act, P.L. 1991, c.378, as amended by P.L. 1992, c.102.

(b) This subchapter shall apply to all physician assistants licensed pursuant to the provisions of this subchapter and to anyone within the jurisdiction of the Physician Assistant Advisory Committee.

13:35-2B.2 Definitions

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

"Board" means the State Board of Medical Examiners.

"Committee" means the Physician Assistant Advisory Committee.

"Direct supervision" means supervision by a plenary licensed physician which shall meet all of the conditions established in N.J.A.C. 13:35-2B.10(b).

"Director" means the Director of the Division of Consumer Affairs.

"Licensee" means a physician assistant licensed pursuant to this subchapter.

"Licensed personnel" means health care practitioners licensed in the State of New Jersey to perform specific duties in the health care field.

"Physician" means a person who holds a current, valid license to practice medicine and surgery in this State.

"Physician assistant" means a person who holds a current, valid license to practice as a physician assistant in this State.

"Physician designee" means a plenary licensed physician who is assigned by the supervising physician in case of his or her temporary

absence and whose scope of practice encompasses the duties assigned to a physician assistant.

"Supervising physician" means a plenary licensed physician in good standing who, pursuant to N.J.S.A. 45:9-27.18, engages in the direct supervision of physician assistants whose duties shall be encompassed by the supervising physician's scope of practice.

13:35-2B.3 Practice requirements

(a) A licensee may engage in clinical practice in any medical care setting provided that:

1. The licensee is under the direct supervision of a physician pursuant to the provisions of N.J.A.C. 13:35-2B.10;

2. The licensee limits his or her practice to those procedures authorized pursuant to N.J.A.C. 13:35-2B.4;

3. Upon initial involvement in a patient's course of care or treatment, the licensee or the supervising physician advises the patient that authorized procedures are to be performed by the physician assistant;

4. The licensee conspicuously wears an identification tag using the term "physician assistant" whenever acting in that capacity; and

5. The licensee complies with the recordkeeping requirements set forth in N.J.A.C. 13:35-2B.11.

(b) The licensee shall file with the Board a notice of employment for each place of employment, on forms provided by the Committee, within 10 days after the date on which employment commences. Furthermore, the licensee shall report to the Board any change in employment or supervisor within 10 days of the change.

13:35-2B.4 Scope of practice

(a) A licensee who has complied with the provisions of N.J.A.C. 13:35-2B.3 may perform the following procedures on a discretionary and routine basis:

1. Approaching a patient to elicit a detailed and accurate history, perform an appropriate physical examination, identify problems, record information and interpret and present information to the supervising physician, determine and implement therapeutic plans jointly with the supervising physician and compile and record pertinent narrative case summaries;

2. Suturing and follow up care of wounds including removing sutures and clips and changing dressings, except for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;

3. Providing patient counseling services and patient education consistent with directions of the supervising physician;

4. Assisting a physician in an inpatient setting by conducting patient rounds, recording patient progress notes, determining and implementing therapeutic plans jointly with the supervising physician and compiling and recording pertinent narrative case summaries;

5. Assisting a physician in the delivery of services to patients requiring continuing care in a private home, nursing home, extended care facility, private office practice or other setting, including the review and monitoring of treatment and therapy plans;

6. Facilitating the referral of patients to, and promoting their awareness of, health care facilities and other appropriate agencies and resources in the community;

7. Collecting fluids for diagnostic purposes, including, but not limited to, blood, urine, sputum and exudates;

8. Placing and utilizing access catheters and tubes for diagnostic, therapeutic or interventional purposes, including, but not limited to, intravenous, arterial, nasogastric and urinary;

9. Performing minor surgical procedures such as simple excisions, incision and drainage, debridement and packing of wounds;

10. Applying and removing medical and surgical appliances and devices such as splints, casts, immobilizers, traction, monitors and infusion pumps;

11. Management of emergency and life threatening conditions;

12. Performing uncomplicated obstetrical deliveries in a licensed health care facility (which may include a licensed birthing center); and

13. Subject to review by the Board, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the physician assistant.

(b) A licensee who has complied with the provisions of N.J.A.C. 13:35-2B.3 may perform the following procedures, provided the procedures are within the training and experience of both the supervising physician and the physician assistant, only when the supervising physician directs the licensee to perform the procedures or orders or prescribes the procedures, or the procedures are specified in a written protocol approved by the Board.

1. Performing non-invasive laboratory procedures and related studies or assisting licensed personnel in the performance of invasive laboratory procedures and related studies;

2. Giving injections, administering medications and ordering diagnostic studies;

3. Suturing and caring for facial wounds, traumatic wounds requiring suturing in layers and infected wounds;

4. In an inpatient setting, ordering medications and prescribing other than controlled dangerous substances and writing orders to implement therapeutic plans identified pursuant to (a)4 above;

5. In the operating room, assisting a supervising surgeon as a first assistant or as a second assistant when deemed necessary by the supervising surgeon and when a qualified assistant physician is not required by N.J.A.C. 13:35-4.1;

6. Performing other procedures for diagnostic, therapeutic or interventional purposes such as, but not limited to, introduction of contrast material for radiologic studies, use of endoscopic instruments and aspiration of fluid from joints and body cavities, collection of cerebrospinal fluid, biopsy of tissues, placement of central venous catheters or chest tubes, and endotracheal intubation. The supervising physician shall maintain documentation, or ensure that documentation is maintained, evidencing that the physician assistant has the training, experience and proficiency to perform such procedures; and

7. Subject to review and approval by the Board, such other written procedures established by the employer, provided the procedures are within the training and experience of both the supervising physician and the physician assistant.

13:35-2B.5 Eligibility for licensure

(a) An applicant for licensure shall submit to the Board, with the completed application form and the required fee, evidence that the applicant:

1. Is at least 18 years of age;

2. Is of good moral character, evidence of which shall require the applicant for licensure to respond to such inquiry as the Board deems appropriate regarding past and present fitness to practice, and issues pertinent thereto;

3. Has successfully completed an education program for physician assistants which is approved by the Committee on Allied Health Education and Accreditation, or its successor; and

4. Has passed the examination administered by the National Commission on Certification of Physician Assistants (NCCPA), except as set forth in (b) below.

(b) An applicant who submits satisfactory proof that he or she holds a current license, certification or registration to practice as a physician assistant in a state which has standards substantially equivalent to those of this State shall be deemed to satisfy the examination requirement set forth in (a)4 above.

13:35-2B.6 Refusal to issue, suspension or revocation of license

(a) The Board may refuse to issue or may suspend or revoke any license issued by the Board for any of the reasons set forth in N.J.S.A. 45:1-21.

(b) Prior to any license suspension or revocation, the licensee shall be afforded the opportunity for a hearing pursuant to the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and 52:14F-1 et seq., and the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

13:35-2B.7 License renewal, continuing education requirement

(a) The Board shall not issue a biennial license renewal unless the applicant submits, with the renewal application, proof that he or she completed courses of continuing professional education of the types and number of credits specified in N.J.A.C. 13:35-2B.8.

(b) Falsification of any information submitted with the renewal application may result in an appearance before the Board or a duly appointed Committee thereof and, after due notice to the licensee

and the opportunity for a hearing pursuant to the Administrative Procedure Act and the Uniform Administrative Procedure Rules, penalties and/or suspension or revocation of the license.

(c) The Board will, from time to time, conduct inquiries among licensees on a random basis to determine compliance with continuing education requirements.

13:35-2B.8 Credit-hour requirements

(a) Each applicant for a biennial license renewal shall be required to complete, during the preceding biennial period, a minimum of 40 continuing education credit hours in category I courses approved by the American Medical Association, the American Academy of Physician Assistants, the American Academy of Family Physicians, the American Osteopathic Association or the Accreditation Council on Continuing Medical Education. The Board reserves the right to review and approve continuing education courses offered by entities other than those set forth above.

(b) Fifteen credits may be carried over into a succeeding biennial period only if earned during the last six months of the preceding biennial period.

13:35-2B.9 Waiver of continuing education requirement

(a) The Board may, in its discretion, temporarily waive continuing education requirements on an individual basis for reasons of hardship, such as illness or disability, or other good cause.

(b) Any licensee seeking a waiver of the continuing education requirements must apply to the Board in writing and set forth with specificity the reasons for requesting the waiver. The licensee shall also provide the Board with such additional information as it may reasonably request in support of the application.

13:35-2B.10 Supervision

(a) A physician assistant shall engage in practice only under the direct supervision of a physician.

(b) The physician assistant shall not render care unless the following conditions are met:

1. In an inpatient setting, the supervising physician or physician-designee is continuously or intermittently present on-site with constant availability through electronic communications for consultation or recall;

2. In an outpatient setting, the supervising physician or physician-designee is constantly available through electronic communications for consultation or recall;

3. The supervising physician regularly reviews the practice of the physician assistant;

4. The supervising physician personally reviews all charts and patient records and countersigns all medical orders as follows:

i. In an inpatient setting, within 24 hours of the physician assistant's entry of the order in the patient record; and

ii. In an outpatient setting, within a maximum of seven days of the physician assistant's entry of the order in the patient record; and

5. The following supervisory ratios are met:

i. In a private practice which is not hospital based or institutionally affiliated, no more than two physician assistants to one physician at any one time;

ii. In all other settings, no more than four physician assistants to one physician at any one time.

(c) Upon application to the Board, the Board may alter the supervisory ratios set forth in (b) above.

(d) A supervising physician who is a department head may assign physician assistants under his or her supervision to attending and staff physicians, who shall be responsible for the practice of the physician assistant during the assignment. In all other settings in which a physician assistant is employed, the supervising physician of record shall be considered to be the person responsible for the practice of the physician assistant.

13:35-2B.11 Recordkeeping

(a) Licensees shall make contemporaneous, permanent entries into professional treatment records which shall accurately reflect the treatment or services rendered. To the extent applicable, professional treatment records shall reflect:

1. The dates and times of all treatments;
2. The patient complaint;
3. The history;
4. Findings on appropriate examination;
5. Progress notes;
6. Any orders for tests or consultations and the results thereof;
7. Diagnosis or medical impression; and
8. Treatment ordered. If medications are ordered, the patient record shall include:

i. Specific dosages, quantities and strengths of medications;

ii. A statement indicating whether the medication order is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

iii. The physician assistant's full name, printed or stamped, and the license number; and

iv. The supervising physician's full name, printed or stamped.

(b) If the information required pursuant to (a)8iii and iv appears at least once in the patient record, it need not be repeated each time a medication order is entered in the patient record.

(c) The physician assistant shall sign each entry in the patient record and record the designation "PA-C" following his or her signature.

(d) To the extent a physician assistant is charged with independent responsibility for the provision of information used to prepare bills and claims forms, such information shall accurately reflect the treatment or services rendered.

13:35-2B.12 Requirements for issuing prescriptions for medications

(a) A physician assistant may issue prescriptions only in accordance with the following conditions:

1. A physician assistant may issue prescriptions only in an inpatient setting.

2. A physician assistant shall not issue prescriptions for controlled dangerous substances.

3. A physician assistant shall provide the following on all prescription blanks:

i. The physician assistant's full name, professional identification ("PA-C"), license number, address and telephone number. This information shall be printed or stamped on all prescription blanks;

ii. The supervising physician's full name, printed or stamped;

iii. A statement indicating whether the prescription is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

iv. The full name, age and address of the patient;

v. The date of issuance of prescription;

vi. The name, strength and quantity of drug or drugs to be dispensed and route of administration;

vii. Adequate instruction for the patient. A direction of "p.r.n." or "as directed" alone shall be deemed an insufficient direction;

viii. The number of refills permitted or time limit for refills, or both;

ix. The signature of the prescriber, hand-written; and

x. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the physician assistant's initials next to the chosen option, in addition to the space required for the signature in (a)3ix above.

(a)

DIVISION OF CONSUMER AFFAIRS

Weights and Measures

Proposed Readoption with Amendments: N.J.A.C. 13:47B

Authorized By: William J. Wolfe, State Superintendent, Division of Consumer Affairs, Office of Weights and Measures.

Authority: N.J.S.A. 51:1-61.

Proposal Number: PRN 1993-629.

Submit comments by December 15, 1993 to:
William J. Wolfe
State Superintendent
New Jersey Office of Weights & Measures
1261 Routes 1 and 9 South
Avenel, NJ 07001

The agency proposal follows:

Summary

Pursuant to the provision of Executive Order No. 66(1978), the rules at N.J.A.C. 13:47B will expire on February 21, 1994. As required by the Executive Order, the Office of Weights and Measures has reviewed these rules and determined them to be necessary, reasonable and proper, as amended and supplemented, for the purpose for which they were originally promulgated. These rules protect New Jersey consumers from the use of false or malfunctioning weighing and measuring devices in commercial transactions.

A summary of each section and the proposed amendments are as follows:

N.J.A.C. 13:47B-1.1 currently requires gas station owners and operators to obtain one-gallon and five-gallon standard test measures and mandates a daily pre-sale test of liquid fuel pumps. The proposed amendment deletes the requirement for one-gallon standard test measures because most gas pumps can be legally tested by using the five-gallon test measures.

N.J.A.C. 13:47B-1.2 bans the use of counter tacks or other non-standard linear measures and it requires that all measures of length shall be in conformance with the requirements set forth in the National Bureau of Standards Handbook 44, Specifications, Tolerances, and other Technical Requirements for Weighing and Measuring Devices. Because 11 U.S.C. 271 was amended on August 12, 1988 by Public Law 100-418, with the result that the National Bureau of Standards is renamed as the National Institute of Standards and Technology, this section is being amended to reflect the new name of the National Bureau of Standards.

N.J.A.C. 13:47B-1.4 provides for standard measures for the sale of commodities by liquid measures and mandates certain marking requirements on the liquid measure containers.

N.J.A.C. 13:47B-1.5 provides that all new, modified or altered commercial weighing or measuring devices must be submitted to the State Superintendent of Weights and Measures for type approval and bans the use of non-type approved commercial weighing or measuring devices. This section is being amended to reflect the change in the location of the office of the State Superintendent from Trenton to Avenel, New Jersey.

N.J.A.C. 13:47B-1.6 provides for direct customer access to the weighing, indicating and recording elements of commercial scales.

N.J.A.C. 13:47B-1.9 regulates the use of portable self-contained vehicle scales.

N.J.A.C. 13:47B-1.10 bans the use of household type scales for commercial transactions.

N.J.A.C. 13:47B-1.12 sets the limits of weighings on wagon scales.

N.J.A.C. 13:47B-1.14 limits the use of uncompensated spring scales to the sale of fruits and vegetables and provides for a use limitation for such scales.

N.J.A.C. 13:47B-1.16 provides that official inspection certificates be retained by the owner/operator of commercial weighing devices or on a vendor's vehicle as the case may be; and provides that these certificates are the official authority to use the officially inspected and tested weighing or measuring devices in commercial transactions. This section is being amended to clarify that in cases where the weighing or measuring devices are installed at a fixed location, the certificates shall be available at that location and in cases where the weighing or measuring devices are installed on the vehicles, the certificates shall be carried on the vehicles on which the devices are installed.

N.J.A.C. 13:47B-1.17 sets forth the minimum height that hanging scales may be positioned to insure customer access and readability.

N.J.A.C. 13:47B-1.19 provides that converted, altered or modified gasoline dispensers, which were previously type-approved by the State Superintendent, will have type-approved rescinded. It also provides that notification of such alteration(s) be provided to all weights and measures officers.

N.J.A.C. 13:47B-1.20 adopts the National Bureau of Standards Handbook 44 as the legal requirements for all weighing and measuring devices used for commercial and law enforcement purposes in the State of New Jersey and reserves the State Superintendent's right to amend or supplement these requirements for cause. This section is being amended to reflect the new name of the National Bureau of Standards.

N.J.A.C. 13:47B-1.24 provides for a registry for security sealing devices applied to commerical weighing and measuring devices by licensed repairmen. This registry provides a means to trace faulty or fraudulent repairs and/or adjustments to commercial weighing and measuring devices through an identification system controlled by the State Superintendent.

N.J.A.C. 13:47B-3.1 provides civil penalties for violation of or non-compliance with the provision of this chapter. This section is being amended to restate the penalty provision of N.J.S.A. 51:1-89 in that it applies to any violation of or non-compliance with any provisions of this chapter for which a specific penalty has not been provided.

N.J.A.C. 13:47B-4.1 sets forth the minimum training requirements for a new Weights and Measures Officer prior to the issuance of either a badge or credential to that person by the State Superintendent.

Social Impact

The proposed readoption and amendments to N.J.A.C. 13:47B will allow the Office of Weights and Measures to continue in full force and effect the beneficial consumer protection programs which resulted from the original promulgation of the regulations. The rules will continue to regulate the use of commercial weighing and measuring devices in New Jersey.

The public benefits from these regulations in that the regulations provide for a third party control of commercial weighing and measuring devices which are used to buy and sell commodities in the market-place.

Economic Impact

The amendment to N.J.A.C. 13:47B-1.1, which eliminates the requirement that gasoline dealers obtain a proper standard measure in capacity of one gallon, will reduce the compliance costs for such dealers. Other than in regard to N.J.A.C. 13:47B-1.1, the proposed readoption and amendments of the regulations involve no substantive changes and will merely promulgate the existing regulatory program. As such, the Office of Weights and Measures foresees no additional economic impact on either the business owners or consumers. Some econmic impact will continue to be felt, however, based on existing regulations that have been proposed to be readopted without change. Those regulations consist of the following: N.J.A.C. 13:47B-1.1, which requires gasoline dealers to obtain a proper standard measure on capacity of five gallons; and N.J.A.C. 13:47B-1.5, which requires manufacturers of weighing and measuring devices to be distributed or installed in New Jersey to be submitted for inspection by the State Superintendent of Weights and Measures.

Failure to adopt these rules will result in a loss of consumer confidence in the weighing and measuring devices used in the market-place and the buyers and sellers will not be afforded an opportunity to exchange goods and services on an equitable basis.

Regulatory Flexibility Analysis

The proposed readoption and amendments of the regulation will in effect merely promulgate the existing regulatory program. This proposal will not impose any additional recordkeeping, reporting, initial capital costs or other costs of compliance on the small business community. However, the rules do impose recordkeeping and compliance requirements on both large and small businesses as that term is defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. and therefore some existing rules that have been proposed to be readopted without change need to be addressed in this analysis. For instance, N.J.A.C. 13:47B-1.16 involves recordkeeping for it requires inspection certificates to be retained by owners or users of weighing or measuring devices inspected by a Weights and Measures Officer. N.J.A.C. 13:47B-1.15 involves reporting for it requires manufacturers of weighing and measuring devices to be distributed or installed in New Jersey to be submitted for inspection by the State Superintendent of Weights and Measures. N.J.A.C. 13:47B-1.1 involves initial capital costs for it requires gasoline dealers to obtain a proper standard measure on capacity of five gallons. N.J.A.C. 13:47B-1.9 may involve other costs of compliance because anyone who utilizes a portable self-contained vehicle scale for on-site weighings pursuant to a construction project contract will need to ensure that a New Jersey weighmaster is available to conduct the weighings and that the scale meets certain specifications regarding its installation, use and inspection.

The Division of Consumer Affairs considers the proposed readoption and amendments of the rules to be necessary for the public health, safety and welfare. No differentiation based upon business size is provided since

to do so would adversely impact the rules intent to provide for and guarantee true and equitable transfer of commodities.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 13:47B.

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

13:47B-1.1 Liquid measuring devices

(a) Dealers using gasoline pumps and other automatic liquid measuring devices for the sale of gasoline and similar liquid fuels shall obtain **a** proper standard [measures] **measure** in [capacities] **a capacity** of [one gallon and] five gallons, for the purpose of making tests to ascertain whether the device is delivering the correct quantity.

(b) (No change.)

13:47B-1.2 Length measuring devices

The use of counter tacks as linear measures is forbidden in this State and all measures of length shall be in conformance with the requirements set forth in [National Bureau of Standards] **the National Institute of Standards and Technology** Handbook 44, Specifications, [and] tolerances **and other technical requirements** for [commercial] weighing and measuring devices.

13:47B-1.5 Type approval

(a) All new types of weighing and measuring devices of any description whatsoever, and all devices of older types to which may be added any alteration of new feature intended or designed as an improvement to such equipment shall, before distribution or installation thereof in the State of New Jersey, be submitted by the manufacturer thereof to the State Superintendent of Weights and Measures, (Trenton) **Avenel**, New Jersey for inspection and approval of type and operation.

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

13:47B-1.16 Inspection certificates

(a) (No change.)

(b) Such certificates shall be available at the place of business of the owner or user **where the weighing or measuring devices are installed** or carried on the vehicle on which any weighing or measuring devices are employed in the vending of commodities.

(c) (No change.)

13:47B-1.20 National [Bureau] **Institute** of Standards **and Technology** Handbook 44

All specifications, tolerances and other technical requirements for weighing and measuring devices contained in **the** National [Bureau] **Institute** of Standards and Technology Handbook [H-44, 1985] **44, 1993 edition** and all future editions together with all amendments and supplements thereto, adopted by the National Conference on Weights and Measures are hereby adopted and promulgated as the legal requirements for all weighing and measuring devices used for commercial purposes and law enforcement in the State of New Jersey; provided, however that the Superintendent of the Office of Weights and Measures of the Division of Consumer Affairs, Department of Law and Public Safety may from time to time further amend or supplement said specifications, tolerances and other technical requirements for the purpose of conforming the needs of any situation affecting the interests of the State and its people.

(a)

DIVISION OF CRIMINAL JUSTICE

Office of the State Medical Examiner

Proposed Readoption with Amendments: N.J.A.C. 13:49

Authorized By: Robert Goode, M.D., State Medical Examiner.
Authority: N.J.S.A. 52:17B-80.
Proposal Number: PRN 1993-628.

Submit comments by December 15, 1993 to:
Robert Goode, M.D.
State Medical Examiner
325 Norfolk Street
Newark, N.J. 07103

The agency proposal follows:

Summary

N.J.A.C. 13:49 provides the standards for procedures and investigations by county and State Medical Examiners and the training and experience requirements attendant to the positions of county medical examiner, deputy or assistant county medical examiners, and forensic pathologists.

Pursuant to Executive Order No. 66(1978), this chapter expires on December 16, 1993. The Office of the State Medical Examiner has reviewed these rules and found them to be necessary, reasonable and proper for the purposes for which they were originally promulgated. The Office of the State Medical Examiner has also proposed amendments and new rules to further clarify linguistic interpretations and to streamline and clarify the flow of information.

N.J.A.C. 13:49-1.1 through 1.7 set forth the circumstances under which postmortem examinations are mandated or discretionary; prescribes the procedures by which postmortem examination investigations are transferred from the county where the investigation was initiated to the county with jurisdiction over the death; provides procedures for postmortem examinations where the death involved military personnel killed in aircraft accidents; provides the purposes for which postmortem examinations may properly be performed and the necessary standards of these examinations, incorporates statutory requirements governing religious objections to autopsy, N.J.S.A. 52:17B-88.1 et seq.; and describes the investigative standards and procedures applicable to unidentified decedents.

N.J.A.C. 13:49-2.1 through 2.3 set the requirements for the collection of suitable specimens for the determination of the alcohol or drug content of bodily fluids and tissues and provides for their proper preservation.

N.J.A.C. 13:49-3.1 through 3.3 set forth the circumstances under which autopsy reports may be released; set the fees to be charged for copies of the reports; and require the State Medical Examiner to maintain files of every death examination.

N.J.A.C. 13:49-4.1 sets forth the standards for the establishment and maintenance of refrigerated storage space to be kept by county medical examiners for the preservation of dead bodies, and requires sufficient facilities to perform the examination of dead bodies under investigation.

N.J.A.C. 13:49-5.1 mandates the responsibilities of a legally authorized physician medical examiner and requires that the medical examiner be on duty at all times to investigate deaths occurring within the jurisdiction of each county. The medical examiner on duty is required to cooperate and coordinate with the county prosecutor in the conduct of a criminal investigation.

N.J.A.C. 13:49-6.1 requires the medical examiner to establish proper identification of the decedent, and enumerates procedures for the proper completion of the death certificate.

N.J.A.C. 13:49-7.1 sets forth the standards for the training and experience requirements of the county medical examiner, deputy or assistant county medical examiner and forensic pathologist.

N.J.A.C. 13:49-8.1 requires the State Medical Examiner to evaluate and enforce the eligibility standards applicable to county medical examiner, deputy or assistant county medical examiner and forensic pathologist, and provides for proceedings for the restriction of or removal from their duties. Notice of the proceedings and an opportunity to be heard, in accordance with the Administrative Procedure Act, are required.

Proposed N.J.A.C. 13:49-1.2 will eliminate the inconsistency in language that exists between the section on mandatory autopsies (N.J.A.C. 13:49-1.1) and this section on discretionary autopsies and will continue the medical examiner's responsibility to conduct an autopsy in prisoner deaths that are of prime concern to the public.

Proposed N.J.A.C. 13:49-1.7 expands by four days the maximum time for information entries into National Crime Information Center (NCIC). Experience has shown that a seven day requirement is a reasonable time period to gather all the necessary information thereby obviating the practice of repetitive piecemeal entries into the NCIC database.

N.J.A.C. 13:49-2.1 is amended to relieve the medical examiner of the obligation to collect specimens in instances where the decision is made that an autopsy is not necessary in the public interest. The original

wording of this section seemed to imply that an autopsy had to be performed in all cases of certain categories of death when death occurred within 48 hours of the incident. Some of these deaths are found not to require autopsy, and the regulation was found to be unnecessarily onerous.

N.J.A.C. 13:49-2.2 as amended relieves the medical examiner of the obligation to collect specimens in instances where the decision is made that an autopsy is not necessary in the public interest. The original wording seemed to imply that an autopsy had to be performed in all cases of certain categories of death when death occurred within 48 hours of the incident. Some of these deaths are found not to require autopsy, and the regulation was found to be unnecessarily onerous.

N.J.A.C. 13:49-3.1 as proposed will clarify recordkeeping requirements and the availability thereof. This amendment reflects recent court decisions (see, for example, *Shuttleworth v. The City of Camden,* 258 *N.J. Super.* 573 (App. Div. 1992)). It responds to the need of treating physicians to comply with quality assurance requirements and the State Master Plan for the delivery of quality regional health care. It also responds to the need for blood relatives to have access to medical information.

N.J.A.C. 13:49-3.3(d) as amended will assure that all autopsy reports are available to all persons with a proper interest in a timely fashion, not only the selected categories specified in the earlier version.

Proposed N.J.A.C. 13:49-3.3(g) requires that all Reports of Investigation by Medical Examiner (RIME), supplemental investigative reports, original autopsy reports and amendments thereto be maintained as signed, paper documents for a minimum of five years. If, after this period, the custodian of the records no longer deems it feasible to retain the "hard" paper copies, they may be photographed, microphotographed or microfilmed according to standards and procedures established by the Bureau of Archives and History in the Department of Education, with the approval of the State Records Committee. However, the originals may not be destroyed unless the Bureau of Archives and History shall provide written consent to such destruction or disposition pursuant to N.J.S.A. 47:3-26. This amendment will assure that the data required to be produced and maintained by the medical examiner would be available in hard copy for the specified period of time thereby being less amenable to untraceable alterations when such records are kept solely in an electronic format and data base. This will provide an acceptable degree of record integrity.

Proposed N.J.A.C. 13:49-5.1(g) supplements the obligation of the medical examiner to obtain information of a chemical, physical, medical, or toxicological nature in instances where the decedent has survived the initial event and when the appropriate initial evidentiary specimens have been removed or sequestered in the hospital. This amendment will permit the medical examiner to fully investigate the essential facts concerning the medical causes of death.

Proposed N.J.A.C. 13:49-6.2 requires a medical examiner to complete and forward the HIV Confidential Case Report of the New Jersey Department of Health whenever the medical examiner establishes a new diagnosis or confirms a suspected diagnosis of Human Immunodeficiency Virus (HIV) infection by autopsy. This amendment emphasizes the relationship between the medical examiners and the need for timely notification of the public health agency which is required to monitor the epidemic of HIV infection in New Jersey.

N.J.A.C. 13:49-7.1 as amended reflects changes in the process of accrediting medical specialists in forensic pathology and clarifies the specific criteria by which medical examiners may be eligible to practice in the New Jersey medical examiner system.

Social Impact

Readoption of these rules will assure the continued quality of medical examiner personnel, preserve the integrity of post mortem examinations and facilitate the efficiency or reliability of criminal homicide investigations. The proposed amendments and new rules are expected to permit medical examiners to formulate more accurate opinions concerning death by accessing hospital records whenever death occurs within 48 hours of the incident suspected of being the proximate cause of death. Medical examiners will have a clearer understanding of their obligations during and after death investigations. The Department of Health will receive notice of each diagnosis of HIV so it may fulfill its mission of monitoring the epidemic of the Human Immunodeficiency Virus. The amendments will clarify and resolve the competing policy considerations involving the disclosure of medical examiner reports and findings to appropriate persons and agencies. Readoption will also assure that timely and accurate medical records are kept on file to assist in the answering of medical inquiries by family members and other interested parties in the future.

Economic Impact

The proposed readoption and amendments are not expected to create any significant increases in the cost of providing medical examiner services to the public. The elimination of collecting certain specimens in cases not requiring autopsies will relieve a confusing and unnecessary burden. The amendments will define and clarify the release procedures for medical examiner information. Because the State and county medical examiners' offices are such small but highly specified offices, their budgets do not impact on the overall State and county budgets in a significant fashion.

Regulatory Flexibility Statement

The rules proposed for readoption with amendments do not require a regulatory flexibility analysis, since they do not impose any requirements on small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rules and amendments set forth standards and requirements applicable to the conducting of autopsies by State and county medical examiners.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 13:49.

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

13:49-1.2 Discretionary autopsies

In the absence of an objection based on the religious beliefs of the decedent, autopsies may be performed when it appears in the discretion of the county medical examiner to be in the public interest to do so in all cases of human deaths occurring in the following circumstances:

1.-2. (No change.)

3. All [deaths of suspects in police custody and inmates of a jail, penitentiary or prison who are hospitalized and being treated at the time of death and the medical examiner's investigation, review of hospital records and examination of decedent's body reveal an issue of public interest which compels his or her conclusion that an autopsy is necessary, and] deaths of inmates **as defined in N.J.S.A. 52:17B-86(f)** occurring in institutions maintained in whole or in part at the expense of the State or county when the inmate was not hospitalized therein for organic disease;

4.-5. (No change.)

13:49-1.7 Medical examiner's investigative standards for unidentified decedents

(a)-(e) (No change.)

(f) In any event, an NCIC entry shall be made no later than [three] **seven** days following completion of the autopsy incorporating all features of identification, including estimations of age, time of death, height, sex, race, any known medical conditions discovered by autopsy, and a full description of clothing and personal effects. The Unidentified Person File Data Collection Entry Guide may be used as an aid.

(g)-(i) (No change.)

13:49-2.1 Collection of specimens for alcohol determinations

(a) **Whenever the** [All] county medical examiner[s], or the person designated by the State Medical Examiner or county medical examiner to conduct investigations and perform autopsies in a county, **conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq., that person** shall collect suitable specimens for determination of the alcohol content of the blood and brain tissue in all cases of violent death or death under unusual circumstances where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

(b) (No change.)

13:49-2.2 Collection of specimens for narcotic or dangerous drug determination

(a) **Whenever the** [All] county medical examiner[s], or the person designated by the State Medical Examiner or county medical examiner to conduct the investigations and perform autopsies in a county, **conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq.,**

that person shall collect suitable specimens for determination of the drug content of the body fluids and tissues in all cases of violent deaths or deaths under unusual circumstances where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

(b) (No change.)

13:49-3.1 Release of [autopsy findings] **records**

[(a) Copies of the official report of an autopsy performed by the State Medical Examiner, any county medical examiner or other persons designated by the State Medical Examiner to perform autopsies shall not be released except to the next of kin of the decedent, the decedent's legal representative, law enforcement parties in litigation arising from the incident that caused the decedent's death. Any other person or agency with a proper interest in such records may receive a copy of the report after the authorized medical examiner, in consultation with the State Medical Examiner, determines the propriety of the party's interest. If the medical examiner and State Medical Examiner reach different conclusions as to the propriety of the release of the autopsy report, the medical examiner shall abide by the final determination of the State Medical Examiner.]

(a) The records that are required by law to be made, maintained or kept by the County or State Medical Examiner are the Report of Investigation by Medical Examiner, the inventory of property of value, the autopsy report, including its findings and conclusions, and the results of external examinations upon the bodies of deceased persons. Not included within this definition are any records or portions thereof which contain opinions, subjective evaluations or critical analyses.

(b) The medical examiner shall, upon request, make available for inspection during regular business hours the records required to be made, maintained or kept as defined by (a) above and shall produce copies of the requested records upon payment of such reasonable fee as may be provided by this chapter, except as otherwise provided by:

1. The Right to Know Law, N.J.S.A. 47:1A-1 et seq.;

2. Laws covering confidentiality of records such as the AIDS Assistance Law, N.J.S.A. 5C-1 et seq.;

3. Any other law requiring confidentiality of records;

4. The status of an ongoing investigation as defined by Executive Order No. 123(1985); or

5. Whenever medical examiner's records are not yet complete.

(c) Any other records that satisfy the common law definition of a "public record" which may exist in the medical examiner's file may be inspected or copied with the exceptions as noted above in (b) provided the requestor is able to demonstrate that his or her particular interest outweighs the need of the agency and/or the public interest in confidentiality. The propriety of the party's interest in these records shall be determined by the authorized county medical examiner in consultation with the State Medical Examiner whose final determination shall be binding. The next of kin of the decedent, immediate family members, physicians who treated the decedent for his or her last illness or injury, the decedent's legal representative, law enforcement agencies, or attorneys or insurance companies representing parties in litigation arising from the incident that caused the decedent's death are presumed to have a proper interest in these records.

(d) In the event that the requestor is unable to demonstrate a proper interest, the County or State Medical Examiner may advise the requestor to seek a court ordered release of records.

[(b)](**e**) Notwithstanding [(a)](**b) and (c**) above, if the death has been referred to the county prosecutor or Attorney General for continuing criminal investigation, only the county prosecutor or Attorney General may disclose the autopsy findings. When a party seeks the autopsy report in connection with pending or future criminal litigation, the county prosecutor or Attorney General shall provide the report through the discovery process, in accordance with court rules, or before discovery is undertaken if the prosecutor or Attorney General deems it appropriate.

[(c)] **(f)** Notwithstanding [(a)](**c) and (d**) above, the autopsy report may be furnished to any person upon written authority of the decedent's next of kin or legal representative, unless the death has been referred to the county prosecutor or Attorney General for continuing criminal investigation.

13:49-3.3 Filing of Reports

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

(d) The description and report of gross autopsy findings shall be completed, signed by the physician, and delivered to the county prosecutor and the State Medical Examiner within 30 days of completion of gross dissection [in all homicidal, suspicious, and unusual deaths].

(e)-(f) (No change.)

(g) All original signed documents to include the Report of Investigation by Medical Examiner, supplemental investigative reports, autopsy reports and amendments thereto, shall be maintained a minimum of five years as paper documents and on microfilm permanently thereafter. Any photographing, microphotographing and microfilming shall be in accord with N.J.S.A. 47:3-26.

13:49-5.1 Death investigations; conduct

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

(g) Whenever the county medical examiner, or the person designated by the State Medical Examiner or county medical examiner to perform autopsies in a county, conducts an autopsy pursuant to N.J.S.A. 52:17B-88 et seq. on a decedent who has been treated in a hospital following an incident of external violence, the examiner shall obtain from the hospital any specimens that may have been obtained or removed from the decedent for analysis during the course of diagnosis or treatment where death has occurred within 48 hours of the incident suspected of being the proximate cause of death.

Recodify existing (g) and (h) as (**h**) and (**i**) (No change in text.)

13:49-6.2 Notification of death from contagious, infectious, or communicable diseases

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

(c) Whenever the medical examiner establishes a new diagnosis or confirms a suspected diagnosis of Human Immunodeficiency Virus (HIV) infection by autopsy, he or she shall complete the HIV Confidential Case Report of the New Jersey Department of Health, and forward it to:

New Jersey Department of Health
CN 363
Trenton, New Jersey 08625-0363

13:49-7.1 Eligibility standards of county medical examiner, deputy or assistant county medical examiner, and forensic pathologist

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

(d) Only those county medical examiners, deputy or assistant county medical examiners or forensic pathologists authorized by the State Medical Examiner as competent to perform autopsies pursuant to N.J.S.A. 52:17B-88, shall perform such autopsies. Such person shall be qualified in one of the following categories:

1. Pathologists who shall have completed a two-year program of supervised training in anatomical pathology [appropriate for eligibility to the American Board of Pathology] **approved by the Accreditation Council for Graduate Medical Education of the American Medical Association** are [qualified] **eligible** to conduct death investigations and to perform postmortem examinations and autopsies under the direct guidance and supervision of a [senior] designated pathologist who has already been qualified to practice in an unsupervised capacity in the New Jersey Medical Examiner System, pursuant to [Section 13:49-7.1(d)2] **(d)2 below** and under the general supervision of the State Medical Examiner as provided by law. **The reports prepared by this person shall be countersigned by the designated pathologist who has supervised the autopsy.**

2. Pathologists who [are qualified] **qualify** as anatomic pathologists **as defined in (d)1 above,** and who have at least one year of formal supervised training **in a forensic pathology program approved by the Accreditation Council for Graduate Medical Education,** or two years supervised experience in forensic pathology [suitable for eligibility towards certification by the Speciality Board

in Forensic Pathology may be certified] **in a situation comparable with that of a program accredited by the Accreditation Council for Graduate Medical Education are eligible** to conduct death investigations and to perform postmortem examinations and autopsies under the general supervision of the State Medical Examiner as provided by law.

3. Physicians of any speciality who, by virtue of their experience in a medical examiner system, are able to produce a portfolio of personal case studies acceptable to the State Medical Examiner and who, **further,** are [further] able to demonstrate by interview a knowledgeable approach to forensic problems may be [certified] **declared eligible** to conduct death investigations and to perform postmortem examinations and autopsies under the general supervision of the State Medical Examiner as provided by law.

(e) (No change.)

(a)

NEW JERSEY RACING COMMISSION

Thoroughbred Rules

Horse Ownership or Interest and Licensure Restrictions, Veterinarians and Spouses

Proposed New Rule: N.J.A.C. 13:70-19.44

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1993-615.

Submit written comments by December 15, 1993 to:

Michael Vukcevich, Deputy Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed new rule, assuming adoption, would by regulation prohibit a veterinary practitioner who is licensed as a veterinarian by the New Jersey Racing Commission ("Commission") from also being licensed by the Commission as an owner or trainer. It would further prohibit the spouse of the Commission licensed veterinarian from such licensure and prohibit both the Commission licensed veterinarian and spouse from holding any interest, directly or indirectly, in a race horse.

As noted below, the Commission is of the view that the proposed new rule will likely serve to heighten the public confidence in the sport of horse racing. Although the Commission is of such a view, it recognizes that this proposed new rule will likely generate comment, data, views or arguments both favorable and unfavorable in nature. The Commission, of course, is interested in receiving such comment to determine whether the proposed new rule should be adopted, whether it should not be adopted or whether some alternative thereto should be considered.

Social Impact

The Commission is of the view that the proposed new rule will have a positive influence on the integrity of racing. It will eliminate potential for conflicts of interest, or the appearance of such conflicts, which may exist when a veterinarian treats horses in a race in which the veterinarian or spouse otherwise have an interest or potential interest in the outcome.

Economic Impact

The proposed new rule may, from an economic perspective, adversely affect those veterinarians who desire to become licensed as veterinarians by the Commission (pursuant to N.J.A.C. 13:70-4.1(a)17), as well as their spouses. In the event of such Commission licensure, and assuming adoption of the rule, neither the Commission licensed veterinarian or spouse could be licensed by the Commission as an owner or trainer and neither could hold any interest in a race horse. Accordingly, the inability to pursue such other licensure or interest in a race horse would result in the inability to profit from such endeavors. Of course, such an economic impact could be avoided by a veterinarian failing to seek licensure as a veterinarian by the Commission. In such a case, the veterinarian or spouse could be licensed as an owner or trainer, and could hold an interest in a race horse. In the event of such an election, however, the veterinarian would not be able to engage in veterinary work which requires Commission licensure and an economic impact from such might arise.

The proposed new rule might also impact upon current licensees of the Racing Commission. To the extent that any veterinarian licensed by the Racing Commission was also licensed as an owner or trainer or has a spouse in such licensure category, or holds any interest in a race horse, the licensee and/or spouse would have to determine whether the veterinarian should continue to be licensed as a veterinarian by the Commission.[1] Where a veterinarian impacted by this rule elects not to continue with his or her Commission issued veterinary license, the veterinarian and/or spouse thereof could be licensed as an owner or trainer or hold an interest in a race horse. The potential economic impact in such a case would be attributable to lost profits as a result of not being able to perform the veterinary services which Commission licensure (in the capacity of veterinarian) allows. In the event the veterinarian in such circumstance elected to continue to hold his or her Commission issued veterinary license, the veterinarian or his spouse could not be licensed as an owner or trainer, nor could either hold any interest in a race horse competing in this state. Accordingly, the inability to continue with such licensure or interest in a horse would result in the inability to profit from such endeavors. Moreover, such an election would require divestiture of current holdings on the part of the veterinarian and/or spouse.

[1]It should be noted that Commission records indicate that no veterinarian licensed in such capacity in 1993 is also licensed as an owner or trainer. This is in accord with current policy concerns of the Commission. However, there are situations evident where the spouse of a Commission licensed veterinarian is licensed by the Commission as a trainer and/or owner.

Regulatory Flexibility Analysis

The proposed new rule imposes no reporting or recordkeeping requirements on small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. However, certain veterinarians or spouses thereof may operate as or be affiliated with such small businesses, and the proposed rule would impose compliance responsibilities with respect to such concerns as explained in the Summary above, and with potential economic consequences as discussed in the Economic Impact. In that the purpose of this proposal is to heighten the public confidence in the sport of horse racing, uniform application without regard to business size is deemed necessary to most effectively meet that objective.

Full text of the proposed new rule follows:

13:70-19.44 Horse ownership or interest and licensure restrictions, veterinarians and spouses

(a) Veterinary practitioners, licensed by the New Jersey Racing Commission to practice on the premises of any track association or any grounds under the jurisdiction of the Racing Commission, are not eligible to be licensed as owners or trainers and are prohibited from holding any interest, directly or indirectly, in a race horse.

(b) Disqualification of a husband or wife from having a license applies equally to both.

(b)

NEW JERSEY RACING COMMISSION

Thoroughbred Rules

Trainer Fees

Proposed New Harness Rule: N.J.A.C. 13:70-20.13

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1993-616.

Submit written comments by December 15, 1993 to:

Michael Vukcevich, Deputy Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

This proposed new rule is being advertised for public comment as a result of a recommendation advanced by the Thoroughbred Horsemen's Benevolent Association ("THBA"). The proposed rule provides that, in the absence of a written contract between the thoroughbred owner and trainer, the trainer's commission of an owner's winning purse shall equal 10 percent. The rule calls for the automatic deduction of the commission from an owner's account at the horsemen's bookkeeper's office. However, where a written contract exists between the owner and trainer, and where the owner furnishes written evidence of such contract to the horsemen's bookkeeper, no such deduction shall be made from the owner's winning purse. In such case, the trainer shall be compensated directly by the owner or as the contract may otherwise provide.

The proposed rule further provides for a mechanism to avoid the automatic deduction from the owner's account where a legitimate dispute as to the commission fee due the trainer exists. In such an event, proposed subsection (b) provides that the owner may in writing certify to the horsemen's bookkeeper that a genuine and meritorious dispute exists. Where the owner does so, the horsemen's bookkeeper shall not cause any deductions to be made from the owner's account on behalf of the trainer. The rule additionally provides that the owner, trainer or agent thereof shall have no recourse against the horsemen's bookkeeper or his or her agent for acts or omissions in the administration of the rule. It should be noted that the proposed rule does not preclude the owner and trainer from entering into an agreement for the payment of fees due the trainer for services provided or expenses incurred.

According to the THBA, this proposed new rule is necessary as in many instances no written contract for trainers' commission exists and, as a result, trainers are neither paid as contemplated or, if paid, are not paid in a timely fashion. The THBA has represented to the Racing Commission that a trainer commission equal to 10 percent of an owner's winning purse should be utilized in the proposed new rule, as this is the standard commission in the thoroughbred industry.

Although the THBA views this proposed rule as of benefit to the thoroughbred race industry, the Racing Commission has thus far received one preliminary written negative comment. Among other things, that comment indicates that "[a]n owner does not wish to be forcibly accountable for relinquishing a percentage of his purse monies to his trainer." The Racing Commission, in determining to advertise this proposed new rule for public comment, seeks to elicit further opinion from the industry and interested persons to assist it in assessing whether the proposal should be adopted, whether it should not be adopted or whether some alternative should be considered.

Social Impact

According to the THBA, the proposed new rule will have a positive social impact to the extent that it will insure that thoroughbred trainers receive their commission in a timely manner and in accord with industry standards. However, in light of the comment received by the Racing Commission as noted above, some owners may view this rule as having a negative impact.

Economic Impact

According to the THBA, the proposed new rule would have a positive economic impact in that it would insure that trainers not under written contract for the provision of commission would be compensated in accord with the industry standard, and in a timely fashion. This would, according to the THBA, insure the financial security of trainers and inure to the overall benefit of the sport. The proposed new rule, if adopted, would also affect owners and small businesses which function in the capacity of owners. The rule would create an automatic 10 percent deduction from the owner's winning share of purse, payable to the trainer and to be deducted from the owner's account by the horsemen's bookkeeper. Such an event, however, would not occur in those instances where a contract has been entered into by the owner and trainer and where the owner provides written evidence of such existing contract to the horsemen's bookkeeper, or in the event of a genuine and meritorious dispute as to the commission fees due the trainer. In such situations, no deduction would be made from the owner's winning share of purse.

Additionally, the rule would impose accounting and administrative responsibilities on the horsemen's bookkeeper's office and, to the extent that it imposes such, would have an economic impact on that office. However, neither the owner, trainer or any agent thereof shall have any recourse against the horsemen's bookkeeper or agent thereof for acts or omissions in the administration of the rule.

Regulatory Flexibility Analysis

The proposed new rule does have reporting and recordkeeping implications as concerns owners or trainers, some of which may be considered small businesses as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The rule might result in owners and trainers entering into contracts more readily concerning the commission fee due the trainer. In cases where a contract does exist, to avoid an automatic trainer commission fee deduction from the owner's account with the horsemen's bookkeeper, the owner would be responsible to provide the bookkeeper with written evidence of the existing contract. As such requirement to provide notice is necessary for efficient and proper fee disbursement, and is of minimal cost, no lesser requirements or exemptions are provided based on business size. Additionally, in order to effectuate the proposed new rule, the track association's recordkeeping and disbursement functions would be implicated as a result of the accounting responsibilities imposed on its employee, the horsemen's bookkeeper. However, those track associations are not small businesses as each employ more than 100 people. Therefore, a regulatory flexibility analysis is not required as to those track associations.

Full text of the proposed new rule follows:

13:70-20.13 Trainer commissions

(a) A trainer's commission, in the absence of a written contract between the owner and trainer addressing such fees or providing for no such fees, shall be 10 percent of an owner's share of winning purse to be deducted from an owner's account at the horsemen's bookkeeper's office. It shall be the responsibility of the owner to furnish the horsemen's bookkeeper, at the horsemen's bookkeeper's office, with written evidence of any existing contract concerning commission fees between said owner and trainer. Following receipt of such written evidence of an existing contract from the owner, the horsemen's bookkeeper shall not cause any deduction to be made from the owner's share of winning purse.

(b) In the event the owner fails to provide the horsemen's bookkeeper's office with written evidence of any existing contract for commission fees between said owner and trainer, pursuant to (a) above, the owner may in writing certify to the horsemen's bookkeeper that a genuine and meritorious dispute exists with the trainer concerning commission fees due. In such case, the horsemen's bookkeeper shall not cause any deductions to be made from the owner's account on behalf of the trainer.

(c) The owner, trainer or agent thereof shall have no recourse against the horsemen's bookkeeper, or any agent thereof, for any acts or omissions in administering this rule.

(d) Nothing contained in this rule shall preclude the owner and trainer from entering into an agreement for the payment of fees due the trainer for services provided or expenses incurred.

(a)

NEW JERSEY RACING COMMISSION

Harness Rules

Horse Ownership or Interest and Licensure Restrictions, Veterinarians and Spouses

Proposed New Rule: N.J.A.C. 13:71-9.5

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1993-617.

Submit written comments by December 15, 1993 to:
Michael Vukcevich, Deputy Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed new rule, assuming adoption, would by regulation prohibit a veterinary practitioner who is licensed as a veterinarian by the New Jersey Racing Commission ("Commission") from also being licensed by the Commission as an owner or trainer. It would further

prohibit the spouse of the Commission licensed veterinarian from such licensure and prohibit both the Commission licensed veterinarian and spouse from holding any interest, directly or indirectly, in a race horse.

As noted below, the Commission is of the view that the proposed new rule will likely serve to heighten the public confidence in the sport of horse racing. Although the Commission is of such a view, it recognizes that this proposed new rule will likely generate comment, data, views or arguments both favorable and unfavorable in nature. The Commission, of course, is interested in receiving such comment to determine whether the proposed rule should be adopted, whether it should not be adopted or whether some alternative thereto should be considered.

Social Impact

The Commission is of the view that the proposed new rule will have a positive influence on the integrity of racing. It will eliminate potential for conflicts of interest, or the appearance of such conflicts, which may exist when a veterinarian treats horses in a race in which the veterinarian or spouse otherwise have an interest or potential interest in the outcome.

Economic Impact

The proposed new rule may, from an economic perspective, adversely affect those veterinarians who desire to become licensed as veterinarians by the Commission (pursuant to N.J.A.C. 13:71-7.1(a)12), as well as their spouses. In the event of such Commission licensure, and assuming adoption of the rule, neither the Commission licensed veterinarian or spouse could be licensed by the Commission as an owner or trainer and neither could hold any interest in a race horse. Accordingly, the inability to pursue such other licensure or interest in a race horse would result in the inability to profit from such endeavors. Of course, such an economic impact could be avoided by a veterinarian failing to seek licensure as a veterinarian by the Commission. In such a case, the veterinarian or spouse could be licensed as an owner or trainer, and could hold an interest in a race horse. In the event of such an election, however, the veterinarian would not be able to engage in veterinary work which requires Commission licensure and an economic impact from such might arise.

The proposed new rule might also impact upon current licensees of the Racing Commission. To the extent that any veterinarian licensed by the Racing Commission was also licensed as an owner or trainer or has a spouse in such licensure category, or holds any interest in a race horse, the licensee and/or spouse would have to determine whether the veterinarian should continue to be licensed as a veterinarian by the Commission.[1] Where a veterinarian impacted by this rule elects not to continue with his or her Commission issued veterinary license, the veterinarian and/or spouse thereof could be licensed as an owner or trainer or hold an interest in a race horse. The potential economic impact in such a case would be attributable to lost profits as a result of not being able to perform the veterinary services which Commission licensure (in the capacity of veterinarian) allows. In the event the veterinarian in such circumstance elected to continue to hold his or her Commission issued veterinary license, the veterinarian or his spouse could not be licensed as an owner or trainer, nor could either hold any interest in a race horse competing in this state. Accordingly, the inability to continue with such licensure or interest in a horse would result in the inability to profit from such endeavors. Moreover, such an election would require divestiture of current holdings on the part of the veterinarian and/or spouse.

[1]It should be noted that Commission records indicate that no veterinarian licensed in such capacity in 1993 is also licensed as an owner or trainer. This is in accord with current policy concerns of the Commission. However, there are situations evident where the spouse of a Commission licensed veterinarian is licensed by the Commission as a trainer and/or owner.

Regulatory Flexibility Analysis

The proposed new rule imposes no reporting or recordkeeping requirements on small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. However, certain veterinarians or spouses thereof may operate as or be affiliated with such small businesses, and the proposed rule would impose compliance responsibilities with respect to such concerns, as explained in the Summary above, and with potential economic consequences as discussed in the Economic Impact. In that the purpose of this new rule is to heighten the public confidence in the sport of horse racing, uniform application without regard to business size is deemed necessary to most effectively meet that objective.

Full text of the proposed new rule follows:

13:71-9.5 Horse ownership or interest and licensure restrictions, veterinarians and spouses

(a) Veterinary practitioners, licensed by the New Jersey Racing Commission to practice on the premises of any track associations or any grounds under the jurisdiction of the Racing Commission, are not eligible to be licensed as owners or trainers and are prohibited from holding any interest, directly or indirectly, in a race horse.

(b) Disqualification of a husband or wife from having a license applies equally to both.

(a)

NEW JERSEY RACING COMMISSION

Harness Rules

Daily Triple

Proposed Amendment: N.J.A.C. 13:71-27.54

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1993-614.

Submit written comments by December 15, 1993 to:
Frank Zanzuccki, Executive Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment to the "Daily Triple Rule," N.J.A.C. 13:71-27.54, seeks to remedy what many racing industry followers consider an inequity in the payoff procedures for such races. In a "Daily Triple" race, horses in the dead heat for win are considered as winning horses for the purpose of calculating the pool. The rule, in its present form, calls for an equal distribution of funds in the event of a dead heat for win in any "Daily Triple" race. The proposed amendment calls for the distribution of funds, in the event of a dead heat, to be based on the amount of actual dollars bet on each individual winning horse. The proposed amendment, in calculating such payoff in the same manner as a place pool, will mirror the New Jersey Racing Commission's "Daily Double Rule." See N.J.A.C. 13:71-27.47(q).

Social Impact

The proposed amendment will have a positive social impact to the extent that patrons will now share the pool proceeds in proportion to the amount of winning dollars wagered as to each winning horse.

Economic Impact

The proposed amendment has little economic effect. The amount of money returned to the public will remain constant but the distribution of these funds will become more equitable.

Regulatory Flexibility Statement

The proposed amendment poses no reporting, recordkeeping or other compliance requirements on small business, as defined under the Regulatory Flexibiliy Act, N.J.S.A. 52:14B-16 et seq. The amendment changes the calculating method for determining winning payoffs in the event of a dead heat in a Daily Triple race. The track association which would be required to comply with this new calculation method are not small businesses, as each employ more than 100 people. Therefore, a regulatory flexibility analysis is not required.

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

13:71-27.54 Daily Triple

(a)-(l) (No change.)

[(m) In the event of a dead heat for win between two or more horses in any Daily Triple race, all such horses in the dead heat for win shall be considered as winning horses in the race for the purpose of calculating the pool.]

(m) If any of the daily triple races result in a dead heat, the payoff will be figured the same as a place pool, that is: first the regulation commission is deducted, then the total amount wagered

on the winning combination is deducted, leaving the profit which is divided equally between the holders of the winning combinations.

(n) (No change.)

(a)

NEW JERSEY RACING COMMISSION

Casino Simulcasting

Proposed Amendments: N.J.A.C. 13:72-1.1, 2.9, 4.3, 4.10, 6.2, 7.1 and 8.1

Authorized By: New Jersey Racing Commission, Frank Zanzuccki, Executive Director.

Authority: N.J.S.A. 5:5-30.

Proposal Number: PRN 1993-618.

Submit written comments by December 15, 1993 to:

Michael Vukcevich, Deputy Director
New Jersey Racing Commission
CN 088
Trenton, New Jersey 08625

The agency proposal follows:

Summary

Several technical and substantive amendments are proposed to the New Jersey Racing Commission's ("Commission") rules concerning casino simulcasting. These rules, N.J.A.C. 13:72, were promulgated as joint regulations with the New Jersey Casino Control Commission ("Casino Commission"). The Casino Commission is simultaneously seeking to amend its counterpart regulations, which appear at N.J.A.C. 19:55 (see 25 N.J.R. 4737(a), October 18, 1993).

At N.J.A.C. 13:72-1.1, a definition of "credit voucher machine" is added. The definition of "credit voucher" was amended to provide that it also means a ticket issued by a credit voucher machine, and to clarify that it means a ticket issued by a self-service pari-mutuel machine as a simulcast payout. The definition of "casino pari-mutuel cashier" was amended to delete the reference to self-service pari-mutuel machines and to clarify that such person makes simulcast payouts in a casino simulasting facility.

N.J.A.C. 13:72-2.9 is amended to clarify that sound as well as pictures of simulcast horse races may, subject to Casino Commission approval, be shown in portions of the casino hotel establishment outside the casino simulcasting facility, including non-public areas such as hotel rooms.

An amendment to N.J.A.C. 13:72-4.3 would eliminate the provisions that the Commission and Racing Commission may waive the requirement that a transmission line be a dedicated line only in exceptional cases. It would also eliminate the requirement that any application for waiver document the security of the proposed alternative procedure, since a backup line and cellular phone are in all cases required.

N.J.A.C. 13:72-4.10(c) would be amended to provide that pari-mutuel tickets on a current race which are purchased at a self-service pari-mutuel machine may be cancelled if they could otherwise be cancelled pursuant to the provisions of N.J.A.C. 19:55-4.10(b).

An amendment to N.J.A.C. 13:72-4.10 adding subsection (f) would provide that a casino pari-mutuel cashier may cancel any tickets which a patron requests and does not pay for, provided the tickets are cancelled prior to the sale of any ticket to a subsequent patron.

N.J.A.C. 13:72-6.2 is amended to require licensure of manufacturers, suppliers and repairers of credit voucher machines to casino licensees or hub facilities.

N.J.A.C. 13:72-7.1 is amended to permit a casino licensee and a sending track to agree upon the terms on which they will reconcile simulcast wagers. The parties may not desire to send or receive payment until a certain agreed-upon monetary threshold has been reached, while the current rule requires reconciliation within seven days in all cases.

Finally, N.J.A.C. 13:72-8.1 would be amended to provide that the information required to be made available to patrons in a casino simulcasting facility include the assigned weight, drivers and drivers' colors, but only the maternal grandsire of entered horses.

Social Impact

The proposed amendments are generally technical in nature or intended to clarify the existing rule and procedures and will therefore have little social impact. The public may benefit by the proposed amendments to N.J.A.C. 13:72-2.9, which should permit the showing simulcasting races (but not wagering) in hotel rooms. Additionally, the proposed amendment to N.J.A.C. 13:72-8.1 may benefit the public in terms of enhanced race information availability.

Economic Impact

It would be speculative to predict whether the proposed amendments will have any economic impact. The proposed amendments are generally technical in nature or intended to clarify the existing rules and procedures and, to the extent they do so, may generate a positive econmic impact upon casino licensees and the hub facility.

Regulatory Flexibility Statement

The proposed amendments will only affect the operation of New Jersey casino licensees and the hub facility, none of which is a "small business" as defined under the Regulatory Flexibility Act, N.J.S.A 52:14B et seq. Accordingly, a regulatory flexibility analysis is not required.

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

13:72-1.1 Definitions

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

...

"Casino pari-mutuel cashier" means a casino employee who sells pari-mutuel tickets representing simulcast wagers, sells credit vouchers for simulcast wagers [in self-service pari-mutuel machines], pays cash for credit vouchers, and makes **simulcast** payouts [for winning or refundable pari-mutuel tickets] in a casino simulcasting facility.

...

"Credit voucher" means a ticket issued by:

1. [a] **A** pari-mutuel cashier in exchange for cash, gaming chips, slot tokens or [coin] coupons;

2. A credit voucher machine in exchange for cash; or [by]

3. [a] **A** self-service pari-mutuel machine [for currency, as payment for a winning or refunded pari-mutuel ticket,] **as a simulcast payout** or as the balance returnable after a simulcast wager has been placed.

"Credit voucher machine" means a mechanical, electrical or other device connected to a totalisator which, upon the insertion of cash, automatically issues a credit voucher of an equal value.

...

13:72-2.9 Wagering limited to simulcasting facility

Wagering on simulcast horses within the premises of a casino licensee shall be conducted only in a casino simulcasting facility. However, pictures **and sound** of simulcast horse races may be shown in [on non-casino public] **such other** areas of the establishment as approved by the Commission.

13:72-4.3 Transmission data line

A transmission data line shall be a dedicated line. There shall be a minimum of one backup line, which may be a dial-up line. In addition, each out-of-State sending track shall maintain a cellular phone in its totalisator room. [These requirements] **The dedicated line requirement** may be waived [only in exceptional cases] for good cause shown with the prior written approval of the Commission and Racing Commission. [Any application for such waiver shall be supported by documentation of the precautions which will be taken to assure that the alternative method of transmitting data, which may include the use of cellular phones, will be secure.]

13:72-4.10 Cancellation of tickets

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

(c) [No] **Except for pari-mutuel tickets which may be cancelled pursuant to (b) above, no** pari-mutuel ticket purchased at a self-service pari-mutuel ticket purchased at a self-service pari-mutuel machine on a current race shall be cancelled.

(d)-(e) (No change.)

(f) A casino pari-mutuel cashier may cancel any pari-mutuel tickets which a patron requests, but does not pay for, provided the tickets are cancelled prior to sale of any ticket to a subsequent patron.

13:72-6.2 Simulcast wagering equipment

All manufacturers, suppliers and repairers of simulcast wagering equipment, including totalisators, pari-mutuel machines [and] self-service pari-mutuel machines **and credit voucher machines**, to casino licensees or hub facilities shall be licensed in accordance with the provisions of N.J.S.A. 5:12-92a.

13:72-7.1 Reconciliation with sending tracks

Each casino licensee which conducts casino simulcasting shall, in conformance with information provided by the hub facility, reconcile all simulcast wagers with sending tracks on at least a weekly basis **unless the casino licensee and a sending track agree to a different term of payment, which shall be set forth in the agreement between the casino licensee and sending track.**

13:72-8.1 Race information availability

A casino licensee which conducts casino simulcasting shall make available to patrons of its casino simulcasting facility the following information for each simulcast race: the names of entrants, their sires, dams and **maternal** grandsires, their wagering numbers, post positions, jockeys **or drivers, assigned weight,** morning line odds, owners and owners' colors **or drivers' colors**, trainers, sex color, year of birth; the distance and number of the race; amount of purse; and conditions and claiming price, if any. For harness races, the performance lines for at least the last six races of each entrant shall also be available. The availability of such information, and the procedures for obtaining same, shall prominently be displayed in the casino simulcasting facility. Nothing in this chapter shall preclude a casino licensee from charging patrons a fee for providing such information.

PUBLIC UTILITIES

(a)

BOARD OF REGULATORY COMMISSIONERS

Demand Side Management Resource Plan

Proposed Amendment: N.J.A.C. 14:12-2.1

Authorized By: Board of Regulatory Commissioners, Dr. Edward H. Salmon, Chairman and Jeremiah F. O'Connor and Carmen J. Armenti, Commissioners.

Authority: N.J.S.A. 48:2-13, 52:27F-11(g) and (q) and 52:27F-18.

BRC Docket Number: EX93040117.

Proposal Number: PRN 1993-626.

Submit comments by December 15, 1993 to:

Robert Chilton, Director
Division of Electric
Board of Regulatory Commissioners
CN-350
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The Board of Regulatory Commissioners' (Board) rules pertaining to Demand Side Management (DSM) Resource Plans became effective upon publication in the New Jersey Register on November 4, 1991, at 23 N.J.R. 3368(a). As part of that adoption, the affected electric and gas utilities were required to file a DSM plan no later than February 2, 1992. The plans were filed in a timely fashion and plan review was initiated. A DSM working group consisting of interested persons was established for each utility's plan review and to discuss settlement of the issues. As of September 1, 1993, two utility DSM plans have been approved while five utility DSM plans are still pending before the Board. The rules also provide that the next filing of subsequent DSM Plans will be by March 1, 1994.

Based on the working experience with the first round of DSM Plan filings, the Board has determined that greater regulatory review efficiency can be realized by staggering the filing of utility DSM Plans. Also, as stated above, several DSM Plans filed in February 1992 were substantially modified or refiled subsequent to original filing and are currently pending before the Board. As a result, several plans have not yet been implemented. As such, the rules as presently constituted would require the filing of a new plan before such time as the utility and other parties have had sufficient time to evaluate DSM programs implemented pursuant to the DSM plans filed in February 1992.

Modification of the filing requirements as proposed would provide the Board flexibility to allow additional time or to compress the date for the filing of a DSM Plan. If, in the Board's opinion, there is no need to file within two years, it will have the flexibility to allow more time. Conversely, if it believes a utility should file in less than two years, it can direct a utility to file earlier. If requesting an earlier filing, the Board would give at least six months notice to the utility. This notice provides a more than adequate time frame in which a utility can develop a DSM Plan. This modification will not pose an undue burden on the utilities and will, in fact, provide them with additional time to meet assigned deadlines.

In summary, the Board is proposing that utilities be required to file DSM Plans within two years of the approval of its previous DSM Plan. This will result in staggered filings and will ensure that sufficient time will have passed to implement and evaluate DSM programs previously approved.

Social Impact

Adoption of the proposed amendment will allow the parties to engage in a more detailed review process which will result in additional protection for ratepayers.

Economic Impact

Adoption of the proposed amendments will neither increase utility spending, nor result in the recovery of additional costs from ratepayers. Indeed, the amendments will likely lead to a more timely review process, thus permitting the more timely availabiltiy of programs to customers.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required as these amendments impose no reporting, recordkeeping or compliance requirements on small businessess as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. The amendments place requirements only on investor owned electric and natural gas utilities in the State, all of which are large businesses in that they are major utilities in the State and employ over 100 employees.

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

14:12-2.1 Filing

Every utility shall file [no later than February 2, 1992 and commencing with March 1, 1994 and every two years thereafter,] **within two years of the Board's approval date of its last approved DSM Plan pursuant to N.J.A.C. 14:12,** a DSM Plan for review and approval by the Board. **The Board, however, for good cause, may alter the time for filing. The Board, for reasons such as current DSM Plan success or the need for additional evaluation time, may extend the time for filing, on not less than four months notice. Should the Board direct a utility to file its DSM Plan prior to the end of the two year period, it shall be done only upon a six month notice to the affected utility.**

TRANSPORTATION

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 28 in Somerset County

Proposed Amendment: N.J.A.C. 16:28A-1.19

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Proposal Number: PRN 1993-613.

Submit comments by December 15, 1993 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 Department of Transportation proposes to amend N.J.A.C. 16:28A-1.19 to establish a "time limit parking" zone on Route N.J. 28 in the Borough of Somerville, Somerset County. The provisions of this amendment will improve the flow of traffic and enhance safety along the highway system.

This amendment is being proposed at the request of the Borough of Somerville and as part of the Department's on-going review of current traffic conditions on the State highway system. The Department received a Resolution, adopted August 18, 1993, from the Borough Council of Somerville requesting that a two hour time limit parking zone be established along the eastbound (southerly) side of Route N.J. 28 in Somerville Borough. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs concurred that the establishment of a two hour time limit parking zone along Route N.J. 28 in the Borough of Somerville, Somerset County was warranted. Signs are required to notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendment to establish a two hour time limit parking restriction along Route N.J. 28 in the Borough of Somerville, Somerset County will improve traffic flow and enhance safety. This action was done at the request of locally elected public officials. 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 local government will bear the costs for the installation of appropriate parking restriction 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 fines 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**):

16:28A-1.19 Route 28

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

(e) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "Time Limit Parking" zones where parking is prohibited at all times except in the areas designated below. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following established Time Limit Parking zones.

1. (No change.)

2. In the Borough of Somerville, Somerset County:

i.-ii. (No change.)

iii. Along the eastbound (southerly) side:

(1) Beginning at a point 130 feet east of the easterly curb line of Mountain Avenue to a point 115 feet west of the westerly curb line of West Main Street—Somerset.

(A) Two hours time limit parking from 6:00 A.M. to 2:00 A.M., Monday through Friday excluding weekends and holidays.

(f)-(g) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Route N.J. 71 in Monmouth County
Proposed Amendment: N.J.A.C. 16:28A-1.38

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

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-198 and 39:4-199.

Proposal Number: PRN 1993-612.

Submit comments by December 15, 1993 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 Department of Transportation proposes to amend N.J.A.C. 16:28A-1.38 to establish revised "no stopping or standing" zones on Route N.J. 71 in Spring Lake Heights Borough, Monmouth County. The provisions of this amendment will improve the flow of traffic and enhance safety along the highway system.

This amendment is being proposed at the request of the Borough of Spring Lake Heights and as part of the Department's on-going review of current conditions. The Police Department of Spring Lake Heights Borough recommended a complete prohibition of stopping or standing on both sides of Route N.J. 71 from Park Avenue south to Spring Lake Heights Borough-Sea Girt Borough corporate line. This action was recommended to improve traffic safety conditions. The Borough Council of Spring Lake Heights adopted Resolution #63—1993, July 12, 1993, formalizing this recommendation to the Department of Transportation. The traffic investigation conducted by the Department's Bureau of Traffic Engineering and Safety Programs concurred that the establishment of revised "no stopping or standing" zones along Route N.J. 71 in Spring Lake Heights Borough, Monmouth County was warranted.

N.J.A.C. 16:28A-1.38 has been further amended to:

1. Move text appearing at deleted paragraph (a)1 pertaining to Deal Borough, to paragraph (a)6; and

2. Delete subparagraph (a)7iii, which duplicates text appearing at subparagraphs (a)7i(1) and (2) to comply with the Department's rulemaking format. Signs will notify motorists of the restrictions proposed herein.

Social Impact

The proposed amendment will establish revised "no stopping or standing" zones along Route N.J. 71 in Spring Lake Heights Borough, Monmouth County to improve traffic flow and enhance safety. Appropriate signs will be erected to advise the motoring public.

Economic Impact

The Department and local government will incur direct and indirect costs for mileage, personnel and equipment requirements. The local government will bear the costs for the installation of appropriate parking restrictions 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 fines 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]):

16:28A-1.38 Route 71

(a) The certain parts of State highway Route 71 described in this subsection [are] **shall be** designated and established as "no [parking] **stopping or standing**" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. **In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.**

[1. No parking anytime in Deal Borough along the southbound side of Route 71 (Norwood Avenue) beginning 144 feet from the southerly curb line of Brighton Avenue to a point 40 feet southerly therefrom.

2. No stopping or standing in Bradley Beach Borough along the easterly side from the southerly curb line of Lake Terrace to a point 150 feet southerly therefrom.

3. No stopping or standing in Spring Lake Heights Borough:

i. Along the northbound side:

(1) From a point 85 feet south of the southerly curb line of Ocean Road to a point 65 feet north of the northerly curb line of Ocean Road;

(2) From the northerly curb line of Church Street to a point 120 feet north of the northerly curb line of Church Street;

(3) From the northerly curb line of Pitney Drive to the Spring Lake Heights Borough-Wall Township corporate line.

ii. Along the southbound side:

(1) From the Wall Township-Spring Lake Heights Borough corporate line to the northerly curb line of Allaire Road;

(2) From a point 75 feet north of the northerly curb line of Ocean Road to a point 85 feet south of the southerly curb line of Ocean Road.

iii. Along both sides from 6:00 P.M. to 6:00 A.M.:

(1) From Warren Avenue to the Spring Lake Heights Borough-Sea Girt Borough Corporate line.

4. No stopping or standing in Manasquan Borough along both sides for the entire length of Route 71 within the corporate limits of the Borough of Manasquan.]

1. No stopping or standing in Bradley Beach Borough, Monmouth County:

i. Along the easterly side:

(1) From the southerly curb line of Lake Terrace Avenue to a point 150 feet southerly therefrom.

2. No stopping or standing in Spring Lake Heights Borough, Monmouth County:

i. Along the northbound (easterly) side:

(1) Beginning at the Spring Lake Heights Borough-Sea Girt Borough corporate line to the prolongation of the northerly curb line of Park Avenue.

(2) From the northerly curb line of Church Street to a point 120 feet northerly therefrom.

(3) From the northerly curb line of Pitney Drive to the Spring Lake Heights Borough-Wall Township corporate line.

ii. Along the southbound (westerly) side:

(1) From the Wall Township, Spring Lake Heights Borough corporate line to the northerly curb line of Allaire Road.

(2) From the northerly curb line of Park Avenue to the Spring Lake Heights Borough-Sea Girt Borough corporate line.

iii. Along both sides from 6:00 P.M. to 6:00 A.M.:

(1) From Warren Avenue to Park Avenue.

3. No stopping or standing in Manasquan Borough, Monmouth County:

i. Along both sides:

(1) For the entire length within the corporate limits of Manasquan Borough including all ramps and connections thereto which are under the jurisdiction of the Commissioner of Transportation.

Recodify existing 5. and 6. as **4.** and **5.** (No change in text.)

[7.]**6.** No stopping or standing in Deal Borough, Monmouth County:

i. (No change.)

ii. Along the westerly (southbound) side:

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

(3) Norwood Avenue—Beginning 144 feet from the southerly curb line of Brighton Avenue to a point 40 feet southerly therefrom.

[iii. Along the easterly (northbound) side:

(1) From the northerly curb line of Roosevelt Avenue to the Deal Borough-City of Long Branch Corporate Line.

(2) From 40 feet south of, to 40 feet north of the following intersections:

(A) Brighton Avenue;

(B) Phillips Avenue;

(C) Poplar Avenue;

(D) Morgan Avenue;

(E) Parker Avenue.]

Recodify existing 8. through 10. as **7.** through **9.** (No change in text.)

(b)-(d) (No change.)

TREASURY-GENERAL

(a)

DIVISION OF PENSIONS AND BENEFITS

Public Employees' Retirement System
Election of Member-Trustees
Proposed Amendment: N.J.A.C. 17:2-1.4

Authorized By: Board of Trustees, Public Employees' Retirement System, Wendy Jamison, Secretary.

Authority: N.J.S.A. 43:15A-17.

Proposal Number: PRN 1993-611.

Submit comments by December 15, 1993 to:

Peter J. Gorman, Esq.
Administrative Practice Officer
Division of Pensions and Benefits
CN 295
Trenton, New Jersey 08625

The agency proposal follows:

Summary

The proposed amendment attempts to clarify the guidelines that the Board of Trustees of the Public Employees' Retirement System (PERS) will follow to replace an elected member-trustee of the Board when such a person declines to serve as such member-trustee. Under such guidelines, the Board may select the first runner-up in the election to fill the vacancy of the member-trustee who declines to serve before taking the oath of office. If the first runner-up is unable or unwilling to accept the vacancy, the PERS Board will have the discretion to select the second runner-up or to conduct a new election to fill the Board vacancy.

The proposed amendment also clarifies the current policy that only active members of the PERS may vote in the election of the PERS Board of Trustee's member-trustees, by adding that requirement as a subsection (j).

Social Impact

The proposed amendment to subsection (i) will affect all future elected members of the PERS Board of Trustees, and especially those who will decline to serve on the Board, before taking the oath of office, as well as those individual members of PERS who have voted in an election and/or who are governed by the Board of Trustees. The addition of the provisions to (i) will allow the Board to readily and efficiently continue operation with a full representative membership, thus promoting effective management. The addition of subsection (j) allows only active members to vote in an election for PERS trustees. The promulgation of this long-standing policy will clarify, in accordance with a recent Attorney General's opinion, the practice of allowing only contributing members to vote for members of the Board, and thereby affect the decision-making process. Retired members, however, may serve on the Board.

Economic Impact

With the exception of the cost of conducting a special election if necessary, the proposed amendments will not have an economic impact.

Regulatory Flexibility Statement

A regulatory flexibility analysis is not required because the proposed amendment does not impose reporting, recordkeeping or other compliance requirements upon small businesses. Since the rules of the Division of Pensions and Benefits only impact upon public employers and/or public employees, the amendment will not have any effect upon small business, as the term is defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq.

Full text of the proposal follows (additions indicated in boldface **thus**):

17:2-1.4 Election of member-trustee

(a)-(h) (No change.)

(i) If there are at least three candidates in an election for member-trustee and the victorious candidate dies **or declines to serve as such member-trustee** prior to the beginning of his or her term as trustee, the candidate who obtained the next highest number of votes in that election (that is, the first runner-up) may be selected, at the Board's discretion, to fill the Board vacancy caused by the death **or inability or unwillingness to serve** of the successful candidate. **If the Board selects the first runner-up in such election and that person is unable or unwilling to accept the position, then the Board may, in its discretion, select the candidate who obtained the next highest number of votes in that election or may conduct a new election to fill the Board vacancy. For purposes of this provision, a member-trustee's term begins upon the taking of the oath of office.**

(j) Only active members of the Public Employees' Retirement System may vote in the election of member-trustees of the Board of Trustees of the Public Employees' Retirement System.

OTHER AGENCIES

(a)

CASINO CONTROL COMMISSION

General Provisions
Accounting and Internal Controls
Definitions
Procedure for Collecting and Recording Checks Returned to the Casino After Deposit
Proposed Amendment: N.J.A.C. 19:40-1.2 and 19:45-1.29

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63(c), 69(a) and 99(a).

Proposal Number: PRN 1993-622.

Submit written comments by December 15, 1993 to:

Barbara A. Mattie
Chief Analyst—Operations
Casino Control Commission
Arcade Building
Tennessee Avenue and the Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

The proposed amendments eliminate the position of vice president of casino operations as a specific position which must approve the listing of uncollectible checks along with the chief executive officer and the controller.

As of August 5, 1991, N.J.A.C. 19:45-1.11 was amended to eliminate the position of vice president of casino operations as a required position in a casino licensee's table of organization. Accordingly, the proposed amendment to N.J.A.C. 19:45-1.29 would require that the chief executive officer, a casino key employee and the controller approve the listing of uncollectible checks.

Further, the reference to "with no incompatible function" has been deleted from N.J.A.C. 19:45-1.29(k) since N.J.A.C. 19:45-1.11(a) prohibits incompatible functions in any position. N.J.A.C. 19:40-1.2 has been revised for consistency purposes, adding a definition for "controller."

Social Impact

There will be no social impact on the gaming public or the regulatory agencies. The proposed amendment would give casino licensee more discretion in determining who may be involved in approving uncollectibles.

Economic Impact

No economic impact is anticipated as a result of the proposed amendment.

Regulatory Flexibility Statement

This proposed amendment will only affect the operation of New Jersey casino licensees, and therefore, will not impact on any small business protected under and defined by the Regulatory Flexibility Act, N.J.S.A. 52:14B-16, et seq.

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

19:40-1.2 Definitions

All words and terms which are defined in the New Jersey Casino Control Act (P.L.1977, c.110, as amended) are used in these rules and regulations as defined in that Act. The following words and terms, when used in these rules and regulations, shall have the following meanings, unless the context clearly indicates otherwise.

...

"Controller" is defined in N.J.A.C. 19:45-1.11(b)8.

...

19:45-1.29 Procedure for collecting and recording checks returned to the casino after deposit

(a)-(j) (No change.)

(k) Listings of uncollectible checks shall be approved in writing by, at a minimum, the [Chief Executive Officer, Vice-President of Casino Operations or equivalent executives of a casino licensee that is either a partnership or sole proprietorship and Controller and such] **chief executive officer, a casino key employee approved by the Commission and the controller. All such uncollectible** checks and listings shall be maintained and controlled by accounting department employees. A continuous trial balance of all uncollectible checks shall be maintained by employees of the accounting department [with no incompatible functions]. The continuous trial balance shall be adjusted for any subsequent collections.

(b)

CASINO CONTROL COMMISSION

Applications
Casino Licensees
Employee Reporting and Recordkeeping Requirements
Employee Experiential Hours
Work Permits
Proposed Repeal: N.J.A.C. 19:41-1.7
Proposed New Rules: N.J.A.C. 19:43-9.3 and 9.4

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-63c, 69a, 70c, 89a, 90a, 91a and 106.

Proposal Number: PRN 1993-624.

Submit written comments by December 15, 1993 to:

Antonia Z. Cowan
Senior Counsel
Casino Control Commission
Tennessee Avenue at the Boardwalk
Atlantic City, New Jersey 08401

The agency proposal follows:

Summary

Consistent with recent amendments (P.L. 1991, c.182) to the Casino Control Act (Act), N.J.S.A. 5:12-1 et seq., deleting the need for work permits, this proposal would repeal N.J.A.C. 19:41-1.7, Work permits. The proposal also establishes two new rules N.J.A.C. 19:43-9.3, Employee

reporting and recordkeeping requirements, and N.J.A.C. 19:43-9.4, Employee experiential hours.

N.J.A.C. 19:43-9.3 establishes the necessary reporting requirements to support Commission responsibility as required by N.J.S.A. 5:12-106 (Casino employment) to assure that each employee of every casino licensee is properly registered or possesses a current valid license and codifies the employee status report system. N.J.A.C. 19:43-9.4 establishes the recording and verification of employee experiential hours which are required for specific position endorsements.

The principal improvements over the traditional system of data reports included in the proposed new rule are: provision of uniform data definitions; simplification of reporting; and the elimination of the paper reporting through the use of direct computer communication.

Social Impact

The proposed new rules support the legislative requirements for the Casino Control Commission to oversee employment in the casino industry. The proposed rules create positive, although indirect, benefits to the community in that a well controlled casino employee licensing system helps to achieve stability in the labor force.

Economic Impact

The proposed new rules are restricted to the specific information which casinos will provide to the Commission. The proposed rules seek to reduce both the time necessary to prepare previously required reports and the material cost associated with such production.

Regulatory Flexibility Statement

The proposed new rules affect only casino licensees, none of which are "small businesses" as defined in N.J.S.A. 52:14B-17. Therefore, no regulatory flexibility analysis is required.

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

[19:41-1.7 Work Permits

No casino licensee shall appoint or employ any person as a casino key employee, casino employee, casino hotel employee or otherwise unless a work permit for such employee authorizing his employment in a particular capacity shall have been issued to the casino licensee in accordance with sections 48 and 106 of the Act and the regulations of the Commission prior to the effective date of such appointment or employment.]

19:43-9.3 Employee reporting and recordkeeping requirements

(a) Each casino licensee shall maintain a complete, accurate and current record of the employment and licensing or registration status of each employee. Such record shall include, without limitation, the information in (b) below.

(b) Each casino licensee shall file the following reports with the Commission by electronic data transfer on the first and the 15th calendar day of each month:

1. For each current employee:

i. The license or registration number;

ii. The last name, first name and middle initial as indicated on his or her license or registration;

iii. The date of birth;

iv. The position, represented by a job code that corresponds with a position described in the casino licensee's approved jobs compendium maintained pursuant to N.J.A.C. 19:45-1.11A;

v. The job title as it appears in the casino licensee's approved jobs compendium and which corresponds with the job code required in (b)1iv above;

vi. The initial date of hire in the position indicated by the job code in (b)1iv above;

vii. The effective date of any change in the employee's position or job title;

viii. The access code, if any, assigned to the employee, which code designates the restricted casino areas that the employee is permitted to enter and remain in for purposes of performing his or her normal duties; and

ix. The casino code assigned by the Commission to the casino licensee.

2. For each individual whose employment has been terminated since the date of the most recent report filed with the Commission pursuant to this subsection:

i. The information in (b)1i through vi and (b)1viii through ix above; and

ii. The effective date of termination.

3. A record of any and all designations used by a casino licensee to describe categories of its employees, for example, "full time," "part time," or "seasonal," and the number of employees in each such category.

19:43-9.4 Employee experiential hours

(a) Each casino licensee shall maintain a complete, accurate and current record of the number of actual hours worked in each game by each employee as a pit boss, poker shift supervisor, floorperson, boxperson, and dealer; and the number of actual hours worked by each employee as a slot attendant supervisor, slot attendant, lead slot technician, slot technician, chief slot technician and slot shift manager.

(b) A daily log of the actual number of hours worked by each employee in each position listed in (a) above and, as applicable, in each game shall be maintained in each pit and in the slot department, which log shall:

1. Record the date and time of day when each employee began and ended working in a particular position in a particular game or in the slot department;

2. Be signed by each employee at the times indicated in (b)1 above; and

3. Be signed by the pit boss or the slot shift manager, as appropriate, or his or her designee, verifying the accuracy of the information therein.

(c) Upon the written request of any employee or former employee, a casino licensee shall verify the number of hours worked by such person in any position listed in (a) above identified in the request. Within 30 days of the receipt of such request, the casino licensee shall provide the employee or former employee with the following documents for submission to the Commission:

1. An affidavit from the casino licensee indicating the number of hours worked by the employee or former employee in each position identified in the request and, if applicable, in each game. The affidavit shall be signed by an assistant casino manager (for table game hours) or an assistant slot manager (for slot department hours) or by other management personnel above their level in the casino licensee's organizational structure as filed pursuant to N.J.A.C. 19:45-1.11. The signature of any person authorized to verify experiential hours pursuant to this subsection shall be submitted to the Commission prior to that person performing any such verification.

2. An affidavit from the employee or former employee indicating that he or she, to the best of his or her knowledge, agrees with the hours of employment specified by the casino licensee in its affidavit. The affidavit of the employee or former employee shall be signed and notarized prior to its submission to the Commission.

(d) No casino licensee shall charge any fee whatsoever for providing verification of experiential hours pursuant to this section.

(a)

CASINO CONTROL COMMISSION

Hearings

Proceedings Against Applicants, Licensees and Registrants

Multiple Party Representation

Proposed Amendments: N.J.A.C. 19:42-5.3

Authorized By: Casino Control Commission, Joseph A. Papp, Executive Secretary.

Authority: N.J.S.A. 5:12-69a, 70d, and 70k.

Proposal Number: PRN 1993-623.

Submit written comments by December 15, 1993 to:
Mary S. LaMantia, Senior Counsel
Casino Control Commission
Tennessee and Boardwalk
Atlantic City, NJ 08401

The agency proposal follows:

Summary

Casino Control Commission (Commission) rules require that an attorney obtain Commission approval to represent multiple respondents in the same or substantially similar cases brought pursuant to N.J.S.A. 5:12-108. The proposed amendments are in response to a comment made by the Division of Gaming Enforcement made during adoption of the rules.

The proposed amendments would specify that any response to such a petition must be filed by the Division of Gaming Enforcement within 10 days from the date that the petition is filed. All interested parties would be advised of the decision of the Commission's Chair, or the Chair's designee, within 15 days from the date that the petition is filed. The proposed time frames balance the need for expedient response with the practical necessity of establishing reasonable and attainable time frames.

Social Impact

By establishing reasonable time frames, the proposed amendments should facilitate efficient resolution of the potential conflict of interest situations inherent in multiple party representations. The amendments should thus have a positive impact on the integrity of administrative proceedings before the Commission.

Economic Impact

The proposed amendments should facilitate efficient identification and resolution of potential conflicts of interest in the contested case hearing process. The proposed amendments should thus provide an economic benefit to the casino industry and to the Commission itself.

Regulatory Flexibility Statement

The proposed amendments will impact on attorneys who practice before the Commission though not imposing new requirements on them. Some law firms affected by the amendments may qualify as small businesses as defined in the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq. However, these standards must be consistently applied to all those appearing before the Commission. The public interest would not be served by excluding small businesses from the proposed amendments or providing differing standards.

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

19:42-5.3 Notice of defense; multiple party representation

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

(c) In any circumstance described in (d) below, an attorney who intends to represent more than one party in the same or a substantially related matter shall file a petition for approval no later than 10 days after filing a pleading or entering an appearance in the matter, whichever is earlier. The petitioner shall file such petition with the Commission, or with the Office of Administrative Law if the matter has been transmitted to it, and one copy with the Division.

1. The Division may, within 10 days from the date that the petition is filed, file a written response to the petition with the Commission, or with the Office of Administrative Law if the matter has been transmitted to it.

(d) No attorney shall represent the following parties respondent, unless [the] **a** petition **pursuant to (c) above** is granted:

1.-4. (No change.)

(e) Any petition filed pursuant to [this section] **(c) above** shall be in writing and shall include:

1.-6. (No change.)

(f) Upon receipt of a petition [under subsection (e)] **pursuant to (c) and (e)** above:

1.-2. (No change.)

(g) All interested parties shall be advised of the decision of the Chair or the Chair's designee either orally or in writing no later than [10] **15** days [after receipt of] **from the date that** the petition **is filed**. If the decision is communicated orally, it shall be reduced to writing and mailed to the petitioner within five days.

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

ENVIRONMENTAL PROTECTION AND ENERGY

(a)

ENVIRONMENTAL CLAIMS ADMINISTRATION

Processing of Damage Claims Pursuant to the Sanitary Landfill Facility Closure and Contingency Fund Act

Proposed Repeal and New Rules: N.J.A.C. 7:1I

Authorized By: Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.
Authority: N.J.S.A. 13:1B-3, 13:1D-9 and 13:1E-100 et seq., particularly 13:1E-106 and 13:1E-114.
DEPE Docket Number: 55-93-10/330.
Proposal Number: PRN 1993-630.

A **public hearing** will be held at 9:30 A.M. on Thursday, December 9, 1993 at:

Department of Environmental Protection and Energy
1st Floor Hearing Room
401 East State Street
Trenton, New Jersey

Submit written comments, identified by the Docket Number given above, by December 15, 1993 to:

Janis E. Hoagland, Esq.
Department of Environmental Protection and Energy
Office of Legal Affairs
CN 402
Trenton, New Jersey 08625-0402

The agency proposal follows:

Summary

The Department of Environmental Protection and Energy (Department or DEPE) is proposing new rules governing the processing of claims under the Sanitary Landfill Facility Closure and Contingency Fund Act, N.J.S.A. 13:1E-100 et seq. (the Act).

The Act, passed in 1981 by the New Jersey Legislature, imposed a tax on the owner or operator of every sanitary landfill facility to ensure the proper closure of such facilities and to provide compensation for damages proximately resulting from the operation or closure of sanitary landfills located in New Jersey. N.J.S.A. 13:1E-104. The Legislature recognized in the Act that the improper operation or closure of sanitary landfills could threaten the public and the environment and designed the statute to provide the financial means to mitigate such threats and any actual damage caused by landfill facilities. N.J.S.A. 13:1E-101. The Fund is administered by the Department, N.J.S.A. 13:1E-105, and is available to pay for damages proximately resulting from the improper operation or improper closure of such landfills. N.J.S.A. 13:1E-106.

The responsibility for the processing of damage claims filed under the Act was initially placed in the Office of Sanitary Landfill Claims created by the Department of Environmental Protection (DEP) to administer the Act. In 1987 DEP created the Environmental Claims Administration (ECA) and transferred to this office the responsibility for the processing of damage claims filed against both the Sanitary Landfill Contingency Fund and the Spill Compensation Fund created pursuant to N.J.S.A. 58:10-23.11 et seq.

Regulations governing the processing of Sanitary Landfill Fund damage claims were enacted by DEP in 1983. These rules were general in nature and repeated the statutory definition of "damages" contained in N.J.S.A. 13:1E-106, but specifically added to the statutory definition of property damage "the diminution in fair market value of any real or personal property." The regulations were amended in 1988 with more specific requirements for the processing of property value diminution claims.

The New Jersey Spill Compensation Fund adopted comprehensive new rules in January 1993 for the processing of claims for damages resulting

from discharges of hazardous substances, N.J.A.C. 7:1J. These claims processing rules are equivalent in nature to these proposed Sanitary Landfill Contingency Fund rules. The property value diminution section is identical to the current Sanitary Landfill Contingency Fund rules, which were amended and adopted on June 21, 1993 to reflect the Spill Fund's rules concerning property value diminution.

Much of the proposed new rules are a reflection of the Spill Fund rules. Accordingly, the Department proposes to repeal N.J.A.C. 7:1I, and to propose these comprehensive new rules for the processing of claims under the Act for damages proximately resulting from the improper operation or improper closure of any sanitary landfill facility.

The Department has a fiduciary duty to the Fund to ensure that payments to claimants from the Fund serve the sole purpose of compensating claimants for direct and indirect damages incurred from the improper operations or improper closure of landfills and no other factors.

The proposed new rules reflect the Department's experience since 1983 in processing damage claims against the Fund, as well as its experience in processing claims against the Spill Compensation Fund. The Department has determined that these comprehensive new rules are necessary to ensure efficient and effective use of limited funds and to promote consistent claims processing policy in parallel programs enabling the ECA to provide clear guidance to claimants.

The proposed new rules specify procedures for the entire claims process, including the following: the filing of the claim; the initial acceptance or denial of the claim by the Department; administrative closure of the claim; claim settlement between the claimant and owners, operators, or other persons; settlement between the claimant and the Fund; and administrative hearings of claims. The provisions of the new rules are discussed in more detail below.

N.J.A.C. 7:1I General Provisions

N.J.A.C. 7:1I-1 establishes the purpose, scope and construction of the chapter, provides for the severability of portions of the rules should a court hold a particular section invalid, defines important terms, provides for comprehensive instructions for signatures and certifications, delineates the liabilities for the proper operation and proper closure by owners or operators of sanitary landfill facilities and the strict liability of the Fund for damages, and describes how time periods are computed in the rules.

N.J.A.C. 7:1I-1.1 establishes the scope and purpose of the rules. This section provides that the proposed new rules apply only to claims proximately resulting from the improper operations or improper closure of any sanitary landfill facility.

N.J.A.C. 7:1I-1.2 concerns the construction and applicability of the chapter.

N.J.A.C. 7:1I-1.3 provides that if any portion of this chapter is found to be unconstitutional or invalid by any appropriate court, the remainder of the rules shall not be affected or impaired.

N.J.A.C. 7:1I-1.4 allows the Department to delegate administrative, supervisory or investigative authority to members of the Department's staff. It also allows the Department to enter into contracts on behalf of the Fund for services necessary to resolve issues related to Fund activities such as investigation of property damage claims.

N.J.A.C. 7:1I-1.5 provides definitions for important terms used in the proposed new rules. Several of these definitions are drawn directly or in part from the Act, the Solid Waste Management Act and its regulations, including the following: "closure," "damages," "discover," "disposal," and "sanitary landfill."

The term "closure" is defined in the Solid Waste Management Act, N.J.S.A. 13:1E-102(a), and refers to the activities necessary to properly close and monitor a sanitary landfill facility. The activities include: placement of cover, methane gas monitoring and leachate collection systems.

The term "damages" describes the direct and indirect damages for which the Fund is strictly liable and is taken from the Act, N.J.S.A. 13:1E-106, and includes the costs of restoring, repairing or replacing any real or personal property and the diminution in fair market value of any real property where such damages can be shown by a preponderance of the evidence to have proximately resulted from the improper operations or improper closure of a sanitary landfill facility. Also included are the cost of personal injuries, medical expenses and income lost as a result thereof; and the costs of the design, construction, installation, operation and maintenance of any device or action deemed necessary to mitigate, monitor or analyze threats to the safety or welfare of the State's citizens. Specifically excluded are legal fees and costs normally associated with the sale and transfer of real property.

The term "discovery," as defined, has not been changed from the current definition and is also consistent with the New Jersey Spill Compensation Fund regulations. The term is used in connection with the statutory requirement that claims be filed no later than one year after the date of discovery of damages. N.J.S.A. 13:1E-107.

The terms "disposal" or "disposed" used in this chapter is identical to the definition in the Solid Waste Management Act, N.J.S.A. 13:1E-3.

The term "owner or operator" means and includes, in addition to the usual meanings thereof, every owner of record of any interest in land whereon a sanitary landfill facility is located, has been located, had been located or at any time was located and any person or corporation which owns a majority interest in any other corporation which is the owner or operator of any sanitary landfill facility and every person who operates or operated a sanitary landfill facility and every agent or representative of such operator. The term is important because owners or operators are strictly liable for the proper operations and closure of sanitary landfill facilities pursuant to the Act. N.J.S.A. 13:1E-103.

The term "responsible party" is used to describe those persons who directly or indirectly contributed at any point in time to the occurrence, event, action or damages upon which any person's claim is based.

The term "sanitary landfill facility" is taken from the Solid Waste Management Act, N.J.S.A. 13:1E-3q.

N.J.A.C. 7:1I-1.6 provides that every owner or operator of a sanitary landfill facility or of land upon which a sanitary landfill facility is located, has been located, had been located or at any time was located shall be jointly and severally liable for the proper operations and closure of the sanitary landfill facility and for any direct or indirect damages, no matter by whom sustained, proximately resulting from the improper operations or improper closure of the sanitary landfill facility. This provision is consistent with the Act which also provides that the Fund shall be strictly liable for all direct and indirect damages proximately resulting from the improper operations or improper closure of any sanitary landfill facility.

N.J.A.C. 7:1I-1.7 establishes requirements for signature and certification of claims and affidavits required under these proposed new rules. If the claim or affidavit is by a corporation, the document must be signed by a person authorized to do so under a resolution of the board of directors. This requirement provides the Department with the knowledge that the person signing the document speaks for the corporation. The same reasoning applies to the signature requirements for a partnership or for a municipality, State, Federal or other public agency. This section also requires that the signatory to these claims and affidavits certify to the truth, accuracy and completeness of the information contained within the claim.

N.J.A.C. 7:1I-1.8 provides the address to which all claims, notices, requests and other communications with the Department are to be sent. This section also requires that all such communications, both from the claimant and from other means (for example, many overnight delivery services and courier services) provide a receipt showing the date of mailing and the date of delivery. The requirement is necessary because the Act and the proposed rules contain many time-sensitive requirements which the receipt will establish have been satisfied.

N.J.A.C. 7:1I-1.9 describes how any period of time fixed by or under this proposed chapter is computed. The day of the act or event from which the designated period begins to run is not included. The last day of the period is to be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor a legal holiday. All periods of time computed in "days" under the proposed rules shall mean calendar days.

N.J.A.C. 7:1I-2 Claims Generally

N.J.A.C. 7:1I-2.1 provides that any person claiming to have incurred damages may file a claim. This section prohibits claims by assignees and subrogees of such persons; compensation from the Fund is available only to the person who has sustained the damages which are the subject of the claim. Accordingly, a person selling real property damaged by the improper operation or improper closure of a sanitary landfill facility could not sell his or her interest in the claim along with the property. For the same reasons, an insurance company which pays a claim by a policyholder for damages caused by the improper operation or improper closure of a sanitary landfill facility could not then assert a claim against the Fund to recover the amount paid to the policyholder.

N.J.A.C. 7:1I-2.2 requires the claimant to establish, by a preponderance of the evidence, that the claim satisfies all requirements for eligibility under these rules, and that the amount of the claim correctly reflects the damages sustained by the claimant.

N.J.A.C. 7:1I-2.3 provides that the claim is eligible for compensation only if the claimant has actually suffered damages. Therefore, if a claimant has obtained compensation from other sources (for example, from an insurance carrier or from an owner or operator of a sanitary landfill facility), the claimant could not collect that amount a second time from the Fund. The Department may suspend processing of the claim while the claimant is attempting to obtain compensation from these other sources. In addition, if the damages are contingent or speculative, the claim will be ineligible for compensation. This section also requires the claimant to exercise reasonable diligence and ordinary care prior to purchasing property near a sanitary landfill facility and to take affirmative measures to prevent the damages from occurring in the first instance or from increasing or being aggravated.

N.J.A.C. 7:1I-2.4 concerns multiple overlapping claims for the same damages. For example, if an individual homeowner sells his or her house located near an improperly operated or improperly closed sanitary landfill facility, and the purchaser and the seller file separate claims for the same damages represented by the loss of property value diminution on the subject property, the two claims would be considered overlapping claims subject to this section. To avoid paying double compensation from the Fund, if one claim had already been paid, the second claim covering the same damages would be ineligible for compensation. If the two claims were made simultaneously, the Department may apportion the payment or exclude certain claims for damages based upon a determination of which claimant had actually incurred the damages which are the basis for the submitted claim.

Under N.J.A.C. 7:1I-2.5, a claimant will waive any of his or her damages not set forth in the claim or in response to the Department's request for information.

Under N.J.A.C. 7:1I-2.6, if the claimant deposited, disposed or discarded solid waste as fill at a particular sanitary landfill facility or is the owner or operator of a sanitary landfill facility, the claimant will not be eligible for compensation by the Fund for any damages caused by the sanitary landfill facility.

N.J.A.C. 7:1I-2.6 also provides that claims by a purchaser of land that at one time was used or is still being used as a sanitary landfill facility, are ineligible for compensation unless the claimant can prove that, despite exercising reasonable diligence and intelligence, the claimant did not discover the existence of a sanitary landfill facility on the property until after the property was purchased. For the same reasons, the exclusion from eligibility would apply to a government entity that acquired the property via a voluntary means, such as a foreclosure on a tax lien, rather than an involuntary means such as escheat.

N.J.A.C. 7:1I-2.7 provides that the Department may administratively close a claim. The administrative closure is without prejudice to the claimant, so that the claimant can reactivate the claim.

N.J.A.C. 7:1I-2.8 provides the Department with the discretion to relax procedural requirements to avoid unfairness or injustice. In certain circumstances, requiring strict adherence to the procedural requirements may result in unfairness or injustice, especially when the failure to strictly comply prejudices no one aside from the claimant.

N.J.A.C. 7:1I-2.9 provides that claims for which the claimant demonstrates to the Department's satisfaction that there is an extreme hardship or extreme existing or imminent hazard proximately resulting from the improper closure or improper operation of a sanitary landfill facility may receive priority review.

N.J.A.C. 7:1I-3 Claims Procedure

N.J.A.C. 7:1I-3 sets forth the procedure for submission and initial processing of claims. The procedure is designed to make it as simple as possible to begin the claims process by filing the claim. After the claim is filed, the Department expects to provide guidance to the claimant throughout the claims process.

The Act requires that claims be filed with the Department no later than one year after the date of discovery of damage pursuant to N.J.S.A. 13:1E-107. N.J.A.C. 7:1I-3.1 echoes this requirement. For example, a claimant may sell his or her house due to the improper operation or improper closure of a sanitary landfill facility and discover property value diminution. Under the proposed new rules, the claimant would have one year from the sale of the house to file the claim with the Fund. If the claim was filed after the one year period expired, the Act requires that the Department deny the claim.

Under N.J.A.C. 7:1I-3.2, the claim will be deemed to have been filed as of the date of mailing on the certified mail receipt, if the claim is filed by certified mail. If the claimant uses another means of delivery, the claim will be deemed filed as of the date the Department receives the claim.

N.J.A.C. 7:1I-3.3(a) establishes information that must be included in the claim. To simplify the claimant's preparation of the claim, the document need contain only basic information identifying the claimant and the claim, and a statement that the claimant has incurred damages due to the improper operation or improper closure of a sanitary landfill facility, has not received compensation for the damages from any other source, and is in no way responsible for the improper operation or improper closure of a sanitary landfill facility. These contents of the claim enable the Department to confirm that the claim does not fall into any of the most basic categories of ineligible claims (such as claims by an owner or operator, and claims already compensated from other sources). If the claim is for property value diminution, the claimant is also required to state that he or she intends to sell the subject property. The claim is considered for compensation only after the sale of the property.

Additional information is required to be included only for property value diminution claims made when the claimant has contracted to sell the property before filing the claim. As required under N.J.A.C. 7:1I-4.8(d), additional documentation regarding the sale must be submitted with the claim. Inasmuch as the documents required are of a type which will be readily available at the time the claim is submitted, the requirement should not be a significant burden.

N.J.A.C. 7:1I-3.3(b) enables the Department to request the specific information required to further investigate the claim following receipt of the basic information filed under N.J.A.C. 7:1I-3.3(a). Such information may concern the location of the sanitary landfill facility, whether any person, owner or operator of the sanitary landfill facility has admitted responsibility for the claimed damages, the nature and extent of the damages which the claimant has incurred, other possible sources of compensation for the claimant's damages, and anything else which the claimant believes to be relevant or which the Department believes is necessary to process the claim.

N.J.A.C. 7:1I-3.4 allows for the claimant to amend the claim, or respond to a Department request for information, until the earlier of the approval or denial of the claim by the Department, or the agreement to a settlement among the claimant and one or more responsible persons. This provision will normally prevent a harsh result such as a waiver of all or part of a claim resulting from a failure to correct errors or to submit information about new or different damages. Without provision for amendment, the claimant would have an incentive to delay filing a claim until he or she had collected all information about the claim and was certain of all damages; as a result, many claimants could fail to meet the one year filing deadline necessary for eligibility.

N.J.A.C. 7:1I-3.5 enables the Department, or other persons designated by the Department, to inspect, copy and audit documents supporting the claim; to inspect the damaged real and personal property and other property to which the claimant can provide access; and to allow the Department to direct a medical examination by a physician selected by the Department if the claimant is alleging physical or medical damages as a proximate result of the improper operation or improper closure of a sanitary landfill facility. Access to property and other information will help the Department to verify the existence and extent of damages.

N.J.A.C. 7:1I-3.6 allows the claimant to designate a representative (for example, the claimant's attorney) to receive all communications from the Department in connection with the claim.

Under N.J.A.C. 7:1I-3.7, if, in the Department's opinion, a claim is complete for payment, the Department shall notify the owner or operator of the sanitary landfill facility that is the cause of the claimed damages of the existence of the claim and if there are more related claims.

N.J.A.C. 7:1I-4 Property Value Diminution Claims

This subchapter is nearly identical to subchapter 7 (N.J.A.C. 7:1I-7) in the existing rules, which was adopted at 25 N.J.R. 2715(a), effective June 21, 1993. The only significant change occurs in N.J.A.C. 7:1I-7.1. The current rule states that the property value diminution most proximately result from the operation or closure of a sanitary landfill. The proposed rule says that the diminution must proximately result from the improper operation or improper closure of a sanitary landfill. Additionally, under the proposed rule the subject property, with few exceptions, must be sold to be eligible for property diminution damages.

The Act, as interpreted by the courts, provides that the Fund is strictly liable for any direct and indirect damages including, but not limited to, the reduction in the fair market value of any real property, provided that the reduction in value was caused by the improper operation or improper closure of a sanitary landfill facility in accordance with N.J.S.A.

13:1E-106. Subchapter 4 of the proposed new rules establishes the criteria for measuring this type of damage and for processing claims for such damages.

Generally, N.J.A.C. 7:1I-4 requires that a property value diminution claim is eligible for compensation only if the claimant has sold the subject property (exceptions to this requirement are discussed in more detail below). Under *Citizens for Equity v. New Jersey Department of Environmental Protection,* 126 *N.J.* 391 (1991), the New Jersey Supreme Court unanimously upheld a requirement that the subject property be sold in order to incur damages from property value diminution. Without a sale, the claimant will not realize a loss even if the property value has putatively declined.

N.J.A.C. 7:1I-4 also contains provisions intended to ensure that the sale of the subject property is conducted in good faith. The good faith requirement is necessary because the availability of compensation from the Fund could be expected to reduce any incentive to sell the subject property for the highest price possible. The claimant could rationally accept a much lower price if the Fund would pay any difference.

N.J.A.C. 7:1I-4 provides a different method of handling property value diminution claims than the rules in existence before June 21, 1993. As noted above, the Fund's regulations regarding property value diminution claims were recently amended. As amended, the current regulations duplicate the regulations for processing claims for property value diminution under the Spill Compensation Fund. The existing regulations and these nearly identical proposed rules require far less intervention by the Department in the sale of the subject property than under past Fund regulations. Under Fund regulations in effect prior to June 21, 1993, the Department established the initial sale price of the subject property, and allowed monthly reductions of the price. Under these rules, the Department evaluates the circumstances of the sale as it occurs, leaving the claimant the discretion to establish a sale price in good faith.

N.J.A.C. 7:1I-4.1 provides that claims for diminution of property value are compensable only to the extent that the diminution is directly attributable to a sanitary landfill facility. Under the Act, the Fund cannot pay compensation for diminution which results from causes other than the sanitary landfill facility. If the diminution results wholly or in part from other factors, such as a general decline in the real estate market, the part of the diminution resulting from those other factors would be ineligible for compensation.

N.J.A.C. 7:1I-4.2 establishes requirements which must be satisfied if a property value diminution claim is to be eligible for compensation. Eligibility is based upon the Department's conclusion that the sale of the subject property was conducted in good faith. The good faith determination is based upon appraisals of the subject property under N.J.A.C. 7:1I-4.3, and upon information and documents submitted under N.J.A.C. 7:1I-4.5. In addition, to satisfy the good faith requirement, the claimant is required to list the subject property for sale with one or more licensed real estate brokers who are members of a multiple listing service (or, for non-residential property, which is not normally listed with a multiple listing service, its commercial equivalent).

N.J.A.C. 7:1I-4.3 provides for the Department to obtain two appraisals of the subject property, to be used in assigning a value to the claim under N.J.A.C. 7:1I-4.4: one appraisal stating the value of the subject property as affected by the improper operation or improper closure of a sanitary landfill facility, and one appraisal stating the value absent the effect of the improper operation or improper closure of a sanitary landfill facility. The appraisals will state the value of the subject property as of the time of sale (except for specific types of claims, which the Department may settle without a sale; for those claims, the appraisal will be as of the date of the settlement offer). The appraisals are performed by independent appraisers which the Department selects.

The appraisals will be based upon factors normally applied by qualified real estate appraisers, including sales of comparable properties and income generated by the subject property, including the replacement cost of the subject property. In certain cases, there may be insufficient information to support a meaningful appraisal reflecting the effects of the improper operation or improper closure of a sanitary landfill facility. N.J.A.C. 7:1I-4.3(b), therefore, allows the Department to refrain from obtaining the appraisals in these cases.

N.J.A.C. 7:1I-4.4 provides the method for determining the amount of a property value diminution claim eligible for compensation. If the claimant sells the subject property for a price at least equal to the appraised value of the property as affected by the sanitary landfill facility, the amount eligible will be the difference between the appraised value without considering the sanitary landfill facility and the sale price. However, if the sale price is less than the appraised value as affected by the improper operation or improper closure of a sanitary landfill facility, it is likely that circumstances other than the sanitary landfill facility were responsible for part of the price reduction. For this reason, the amount eligible for compensation would be the difference between the appraised value without considering the impact of the sanitary landfill facility and the appraised value as affected by the impact of the sanitary landfill facility upon the subject property.

The Department may further adjust the amount eligible for compensation, if information other than the sale price and the appraisals support a conclusion that these factors alone do not accurately show the diminution in property value. For example, if the proper closure of a sanitary landfill facility was completed just before the sale, an appraisal would be midleading if it were based on sales of comparable properties which occurred while the closure operation was in progress.

Under N.J.A.C. 7:1I-4.5, the claimant is required to submit documents which will assist the Department in determining that a sale was in good faith. These documents, which include listing agreements, contracts of sale, settlement statements, and affidavits by the claimant and the claimant's realtor, should indicate if a sale is not at arm's length, or if the claimant has received consideration other than the sale price in payment for the subject property.

N.J.A.C. 7:1I-4.6 and 4.7 create exceptions to the requirement that the subject property must be sold for the claim to be eligible for compensation. Under N.J.A.C. 7:1I-4.6, the Department may settle the claim if the claimant is legally unable to sell the subject property as a result of the improper operation or improper closure of a sanitary landfill facility. For example, many municipalities require that a certificate of occupancy (C/O) be issued before property is conveyed; however, the proximity of the sanitary landfill facility may have caused the property to become ineligible for a C/O. The provision does not authorize settlement without a sale if the sanitary landfill facility has created practical rather legal impediments to a sale, because in such circumstances there should still be a price at which a buyer will purchase the subject property.

In the example above, once any legal impediment to a sale is removed, the claimant may sell the property for a price higher than the value on which the settlement was based. For example, the Department may have paid a $20,000 settlement based upon an appraised decline in property value from $100,000 to $80,000. After the proper closure of the sanitary landfill facility, the claimant may sell the property for $95,000, indicating that the settlement was $15,000 too high. To protect and recoup the assets of the Fund from this type of excessive settlement, the new rules provide that as a condition of the settlement, the claimant will grant the Fund a lien on the subject property in the amount of the settlement. In the example described above, the Fund would release the lien upon repayment of the $15,000 excess settlement. The rule provides that the amount of the repayment required will never exceed the amount of the settlement, plus interest.

Settlement of a property value diminution claim without a sale is also appropriate when, as a result of the direct impact of the sanitary landfill facility upon a claimant's property, emergency relocation of the claimant is necessary. N.J.A.C. 7:1I-4.7 authorizes the Department to suspend any or all requirements of N.J.A.C. 7:1I-4.2, 4.3, 4.4 and 4.5 and immediately award compensation if the Department has determined that environmental conditions at a property create a substantial risk of an imminent health or safety hazard to the occupants of the property.

The Department recognizes that a claimant may have begun efforts to sell the subject property before filing the claim, and therefore without knowledge of the requirements of the new rules. To avoid the harsh result of certain denial of the claim, N.J.A.C. 7:1I-4.8 provides the Department with the discretion to consider settling the claim in this circumstance, despite the claimant's inability to comply with all of the requirements of the new rules. The claimant is required to submit all of the documents normally required under N.J.A.C. 7:1I-4.5, but need not submit the listing agreement or realtor's affidavit if these documents are unavailable.

The new rules will apply to all claims processed after the operative date, including claims which were filed before that date. As rules were promulgated in the June 21, 1993 New Jersey Register (25 N.J.R. 2715(a)) for property value diminution (the language of which is identical to these rules), claimants with claims already pending may desire to suspend their claims until they are ready to sell. Accordingly, under N.J.A.C. 7:1I-4.9, the Department will notify all claimants with claims on file of the requirements of the new rules. Within 60 days after the receipt of notice, each such claimant will be required to notify the

Department of his or her election to pursue the claim, suspend it or withdraw it.

A claimant can reactivate a suspended claim at any time upon written request, enabling the claimant to choose the most appropriate time to sell the subject property. In addition, the claim will be reactivated if the Department notifies the claimant that the sanitary landfill facility has been remediated to the satisfaction of the Department. It is the Department's position that any property value dimunition remaining is not attributable to the sanitary landfill facility. Accordingly, the claim would be denied upon this reactivation. The Department may also reactivate a claim upon the conclusion of litigation between the claimant and any responsible party, which litigation concerns the damages which are the subject of the claim.

N.J.A.C. 7:1I-5 Settlement and Determination of Claim

Under N.J.A.C. 7:1I-5.1, the claimant may settle privately with any owner or operator or other responsible party in connection with the sanitary landfill facility which is the proximate cause for the claimant's damages. If the claimant settles with any person in connection with the sanitary landfill facility, any payment that the claimant receives shall be deducted from the amount of compensation considered by the Department in regard to the claimant's damages. Additionally, if the settlement terms release an owner or operator from future liability, the settlement will operate as a waiver by the claimant of all recourse against the Fund, thereby precluding the possibility of double recovery from the responsible persons and from the Fund.

N.J.A.C. 7:1I-5.2 and 5.3 provide that if the claimant has submitted all evidence required by N.J.A.C. 7:1I-3.3 and the Department is satisfied with the evidence, the Department shall issue a Notice of Intent (NOI) consistent with the requirements under N.J.A.C. 7:1I-5.4.

N.J.A.C. 7:1I-5.4 establishes the procedure for offering a payment to a claimant or considering a claim for denial based on available information.

N.J.A.C. 7:1I-5.4(a) enables the Department to issue Notices of Intent (NOI) to pay or deny any claim depending upon whether a claimant has submitted documentation to support a determination of eligibility or whether there is insufficient evidence to support a claim for eligibility. Issuance of an NOI allows a claimant an additional 30 days to submit new information or evidence before the Department's decision becomes final.

N.J.A.C. 7:1I-5.4(b) establishes a time frame for the claimant to either accept or contest the NOI by submitting additional evidence in support of the claim to the Department.

N.J.A.C. 7:1I-5.4(c) states that in response to a NOI, if a claimant has submitted additional information and the Department determines that based on the new information the claim still does not qualify for eligibility for compensation from the Fund, the Fund will inform the claimant of its decision and the claimant will have the opportunity to contest the Department's decision pursuant to N.J.A.C. 7:1I-5.6.

Under N.J.A.C. 7:1I-5.4(d), if the claimant can provide proofs that he or she should receive a greater entitlement than the NOI to pay submitted to the claimant by the Department, the Department will issue a new NOI to pay to the claimant. If no new evidence is submitted to demonstrate that a higher payment is in order, the Department will advise the claimant that its NOI to pay is final as to the claim and will inform the claimant that he or she will have the opportunity to contest the Department's decision pursuant to N.J.A.C. 7:1I-5.6.

N.J.A.C. 7:1I-5.5 establishes the procedure for issuing a denial of a claim which clearly fails to satisfy the requirements for eligibility for compensation under the Fund.

N.J.A.C. 7:1I-5.6 establishes the procedure for how a claimant may contest a final decision of the Fund to deny his or her claim or in the case of a NOI to pay, the reason why the claimant did not accept the offer.

Under N.J.A.C. 7:1I-5.6(a), the claimant has 30 days after receipt of the Department's written statement to request a hearing before the Office of Administrative Law. If the claimant fails to request a hearing before the end of the 30 day period, the failure will act as a waiver of any right to have the claim submitted to a hearing.

N.J.A.C. 7:1I-5.6(b) and (c) establishes the information to be submitted by a claimant for requesting an adjudicatory hearing and the address where the request is to be filed. N.J.A.C. 7:1I-5.6(d) and (e) requires that if the claimant does not submit all of the information required under N.J.A.C. 7:1I-5.6(b), that the request for a hearing will be denied. Additionally, the Department may request additional information from the claimant if the information is needed prior to the claim going before the Office of Administrative Law.

N.J.A.C. 7:1I-5.6(f) states that if the Department grants the hearing request, the Department shall file the request with the Office of Administrative Law.

N.J.A.C. 7:1I-6 Conditions of Payment

N.J.A.C. 7:1I-6 establishes the procedure for the compensation of a claim that meets the eligibility requirements established by the Fund.

Under N.J.A.C. 7:1I-6.1, awards to claimants will be made in either a single lump sum payment or will be divided into separate payments. If the total amount of claims awarded exceeds the current balance in the Fund, then each award will be paid, without interest, on a prorated basis until the award is paid in full.

N.J.A.C. 7:1I-6.2 provides that the Department will not make any payments unless the Department acquires, by subrogation, all of the rights of the claimant to recover such damages caused by the improper operation or improper closure of a sanitary landfill facility. The claimant is required to cooperate fully if the Department decides to commence a civil action to recover any amounts awarded. Under N.J.A.C. 7:1I-6.2(b), the claimant is required to execute a written release for all known damages.

Under N.J.A.C. 7:1I-6.2(c), in all claims concerning property damage where the Department has settled or intends to settle, the claimant shall include a covenant in the agreement of sale and in the deed, which shall run with the land, indicating that the claimant has negotiated with the Department for specific damages and that these damages have been satisfied. Such covenant shall bar further payment from the Fund for similar damages.

Social Impact

The existing claims rules in N.J.A.C. 7:1I have had a positive social impact, by providing claimants with a means of obtaining reimbursement for losses suffered in connection with sanitary landfill facilities. The proposed new rules will increase this positive social impact upon claimants, by providing them with specific orderly procedures for making claims. The proposed new rules are also in harmony with the Spill Compensation Fund rules, N.J.A.C. 7:1J, thereby integrating and enhancing the effectiveness of the Department's policies as they relate to these two programs.

Economic Impact

The existing claims rules in N.J.A.C. 7:1I have had a positive economic impact upon persons who have suffered damages proximately resulting from sanitary landfill facilities. The existing rules have provided a method for these persons to obtain compensation for such damages.

The proposed new rules generally will preserve this positive economic impact, by clarifying and codifying the Department's claims processing practices to parallel rules for the Spill Compensation Fund, N.J.A.C. 7:1J. Both rules are designed to avoid payments for speculative or contingent damages. These rules further enforce the Department's policy that damages must proximately result from the improper operation or improper closure of a sanitary landfill facility. Claims for damages arising from normal operations therefore will not be eligible for compensation under the new rules. This provision will have a negative economic impact upon a certain class of claims which have been or may be filed in connection with currently properly operating or properly closed sanitary landfill facilities.

The Department expects the proposed new rules at N.J.A.C. 7:1I-4, governing property value diminution claims, to have a positive economic impact. The proposed new rules incorporate the recently adopted (June 21, 1993) property value diminution provisions, both of which minimize the role of the Department in the sale of property that has had its value adversely affected by the improper operation or improper closure of a sanitary landfill facility. To the greatest extent practicable, the new rules allow the market to establish the amount of property value diminution. The Department's approach in these rules is to encourage the seller of affected property to act in good faith to obtain the highest price which the market will allow, and to rely upon appraisals and upon evidence of the good faith nature of the sale in evaluating the seller's claim. The Department believes that this approach will result in less property value diminution than an approach which attempted to control the seller's efforts to sell the affected property. For this reason, the Department expects that the sale requirement will have no economic impact upon the property owner, and will have a positive impact by preserving the assets of the Fund.

The economic impact of the claims procedures at N.J.A.C. 7:1I-3 will vary depending upon the nature and complexity of the claim. The Department has structured these procedures to avoid the need for the claimant to incur costs wherever possible. For example, the filing requirement of N.J.A.C. 7:1I-3.3(a) for the initial filing of the claim makes it necessary for the claimant to present only the most basic information about the claim. N.J.A.C. 7:1I-3(b) provides for the Department to request any further information necessary to process the claim, enabling the Department to tailor its informational requirements to the circumstances of a particular claim. The Department expects no significant economic impact to result from the informational requirements of the proposed rules as most of the information required is basic to good recordkeeping practice.

Environmental Impact

The proposed new rules will increase the positive environmental impact of the existing claims rules. As discussed in the Economic Impact statement above, the new rules are designed to prevent several types of potential overpayments of claims, which would otherwise reduce the assets of the Fund available to pay for other claims and the proper closure of sanitary landfills facilities. In addition, with respect to claimed damages proximately resulting from a sanitary landfill facility, the new rules expressly require damages to have been incurred and not merely speculative. In addition, the damages must be proven, by a preponderance of the evidence, to have resulted from the improper operation or improper closure of a sanitary landfill facility. This is consistent with the Act in N.J.S.A. 13:1E-101 which states, in part: "The legislature further finds and declares that the improper operation or closure of sanitary landfill facilities can result in the contamination of surface and ground waters, including potable water supplies; that the migration of methane gas from sanitary landfill facilities can pose a threat to nearby residents and property. . . ." Therefore, it is essential that adequate funds are reserved to ensure proper closure activities at sanitary landfill facilities.

Regulatory and Flexibility Analysis

With respect to property value diminution claims and some other types of claims such as those filed by small businesses, as defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., the proposed new rules require such claimants to submit several documents to be eligible for compensation from the Fund. Claimants must also obtain professional services from real estate brokers thorugh the mulitple listing service (or its commercial equivalent, for claims involving commercial property or other property not normally sold through a mulitple listing service). However, the Department does not believe that this requirement imposes substantial costs upon small businesses because it is likely that such claimants would retain a real estate broker or other appropriate professional to maintain and review records to market such properties even if the proposed new rules did not so require. Compliance with the proposed new rules will not require any initial capital costs or annual costs.

The proposed new rules make no special provision for property value diminution claimants who qualify as small businesses, because any such special provisions would impair the Fund's obligation to protect and insure that the taxes credited to the Fund are spent in a proper manner and for the intended purposes.

Full text of the rules proposed for repeal appear at N.J.A.C. 7:1I.

Full text of the proposed new rules follows:

CHAPTER 1I
PROCESSING OF DAMAGE CLAIMS PURSUANT TO THE SANITARY LANDFILL FACILITY CLOSURE AND CONTINGENCY FUND ACT

SUBCHAPTER 1. GENERAL PROVISIONS

7:1I-1.1 Purpose and scope

(a) This chapter constitutes the rules of the Department concerning the processing of all claims under the Sanitary Landfill Facility Closure and Contingency Fund Act N.J.S.A. 13:1E-100 et seq. (the "Act"), for damages proximately resulting from the improper operation or improper closure of a sanitary landfill facility, pursuant to the Act, including Department procedures for review and decision making regarding such claims.

(b) This chapter is promulgated for the following purposes:

1. To implement the purposes and objectives of the Sanitary Landfill Facility Closure and Contingency Fund Act, N.J.S.A. 13:1E-100 et seq.;

2. To establish rules for administration of the Sanitary Landfill Facility Contingency Fund, established pursuant to the Act, for the purpose of providing prompt and adequate compensation for damages as defined herein; and

3. To protect and insure that the taxes credited to the Fund are spent in a proper manner and for the intended purposes.

7:1I-1.2 Construction and applicability

(a) This chapter shall be liberally construed to allow the Department to fulfill the purposes of the Act concerning claims for compensation for damages proximately resulting from the improper operation or improper closure of a sanitary landfill facility. This chapter shall be construed in conformity with, and not in derogation of, the Act.

(b) This chapter shall apply to the processing of all claims which have not been paid, settled, denied or the subject of a final decision by the Commissioner of the Department on or before the operative date of this chapter, notwithstanding the date upon which any such claim was filed with the Department.

7:1I-1.3 Severability

If any subchapter, section, subsection, provision, clause, or portion of this chapter, or the application thereof to any person is adjudged unconstitutional or invalid by a court of competent jurisdiction, such judgment shall be confined in its operation to the subchapter, section, subsection, provision, clause, portion, or application directly involved in the controversy in which such judgment shall have been rendered and it shall not affect or impair the remainder of this chapter or the application thereof.

7:1I-1.4 Delegation

The Department may delegate administrative, supervisory, or investigatory authority to members of the Department's staff. The Department may enter into contracts on behalf of the Fund or the Department for the performance of services ancillary to the powers and duties of the Department under the Act, including, but not limited to, the performance of claims adjustment services.

7:1I-1.5 Definitions

The following words and terms, when used in this chapter, shall have the following meanings. Where words and terms are used which are not defined herein, the definitions of those words and terms will be the same as the definitions found at N.J.A.C. 7:26-1.4.

"Act" means the Sanitary Landfill Facility Closure and Contingency Fund Act, N.J.S.A. 13:1E-100 et seq.

"Claim" means the claim for damages filed with the Department for recovery from the Fund. The claim includes all documents submitted under this chapter in support of the claim, including without limitation any amendments thereto under N.J.A.C. 7:1I-3.4.

"Claimant" means the person filing a claim.

"Closure" means all activities and costs associated with the design, purchase, construction or maintenance of all measures required by the Department, pursuant to law, in order to prevent, minimize or monitor pollution or health hazards resulting from sanitary landfill facilities subsequent to the termination of operations at any portion thereof, including, but not necessarily limited to, the costs of the placement of earthen or vegetative cover, the installation of methane gas vents or monitors and leachate monitoring wells or collection systems at the site of any sanitary landfill facility, and the cost of general liability insurance, including environmental impairment liability insurance, or an amount sufficient to create a self-insurance fund as may be determined by the Board of Regulatory Commissioners pursuant to section 10 of P.L. 1981, c.306 (N.J.S.A. 13:1E-109), to fund potential claims against the owner or operator of the sanitary landfill facility during the closure and post-closure period.

"Commissioner" means the Commissioner of Environmental Protection and Energy in the State Department of Environmental Protection and Energy.

"Damages" means and includes, but is not limited to, the following:

1. The cost of restoring, repairing or replacing any real or personal property damaged or destroyed;

2. The diminution in fair market value of any real property where such diminution can be shown by a preponderance of the evidence to have solely resulted from the improper operation or improper closure of a sanitary landfill facility. Any property valuation calculations made for the purpose of this chapter shall expressly take into consideration any and all other factors which directly or indirectly affect the fair market value of the property;

3. The cost of any personal injuries, including any medical expenses incurred and income lost as a result thereof; and

4. The costs of the design, construction, installation, operation and maintenance of any device or action deemed necessary by the Department to clean up, remedy, mitigate, monitor or analyze any threat to the environment and public health, safety or welfare of the citizens of this State, including the installation and maintenance of methane gas monitors and vents and leachate monitoring wells and collection systems, and the sampling and analysis of any public or private potable water supply.

5. Damages do not include legal fees incurred in filing claims or for participation in an administrative hearing or any legal action against the Fund and costs normally associated with the listing, sale and transfer of property which is the subject of a claim. Additionally, damages do not include interest on any monetary award assessed against the Fund.

"Department" means the New Jersey Department of Environmental Protection and Energy.

"Discovery" means the time at which the claimant discovers, or by the exercise of reasonable diligence and intelligence should have discovered, that he or she has incurred damages.

"Disposal" or "disposed" means the use of the term which is expressly discussed and defined at N.J.S.A. 13:1E-3.

"Fund" means the Sanitary Landfill Facility Contingency Fund established pursuant to the Act.

"Government entity" means a governing body, department, agency, authority or any other unit of any Federal, State, county or local government or governments, including without limitation a municipal utilities authority.

"Improper operation" or "improper closure" of a sanitary landfill facility means the operation or closure of a sanitary landfill facility that results in a substantial deviation from applicable operation and closure requirements. A de minimis deviation from such applicable operation and closure requirements shall not constitute grounds for a determination that a sanitary landfill facility is being improperly operated or has at any time been improperly closed. A finding of improper operation or improper closure shall only be made upon the basis of a preponderance of the evidence being introduced by the claimant.

"Notice of Intent," or "NOI," means a notice issued by the Department to a claimant pursuant to N.J.A.C. 7:1I-5.4, informing the claimant that the Department intends to pay or deny his or her claim.

"Owner or operator" means and includes, in addition to the usual meanings thereof, every owner of record of any interest in land whereon a sanitary landfill facility is located, has been located, had been located or at any time was located, and any person or corporation which owns a majority interest in any other corporation which is the owner or operator of any sanitary landfill facility and every person who operates or operated a sanitary landfill facility at any point in time and every agent or representative of such operator.

"Person" means any individual or entity, including without limitation, a public or private corporation, company, association, society, firm, partnership, joint stock company, foreign individual or entity and its agents, interstate agency or authority, the United States or any of its political subdivisions or agents, the State of New Jersey and its agents or any of the political subdivisions of or found within the State of New Jersey and their agents, or any of the other meanings which apply to the common understanding of the term.

"Physical intrusion" means the existence of methane gas, leachate or other material emanating from the sanitary landfill facility on or under a claimant's real property.

"Potable water" means drinking water, water for other personal uses, and water for purposes requiring a supply of water which the Department determines is suitable for human consumption pursuant to the Safe Drinking Water regulations set forth at N.J.A.C. 7:10. "Potable water" does not include water for use in fire fighting or for agricultural purposes.

"Responsible party" means any person who directly or indirectly contributed at any point in time to the occurrence, event, action or damages upon which any person's claim or other claims are based.

"Sanitary landfill facility" means a governmentally approved solid waste facility at which solid waste is deposited on or in the land as fill for the purpose of permanent disposal or storage for a period exceeding six months, except that it shall not include any waste facility approved for disposal of hazardous waste.

"Solid waste" means the use of the term which is expressly discussed and defined at N.J.S.A. 13:1E-3(a).

7:1I-1.6 Liabilities for damages

(a) Every owner or operator of a sanitary landfill facility shall be jointly and severally liable for the proper operation and closure of the sanitary landfill facility, as required by law, and for any damages, no matter by whom sustained, proximately resulting from the operation or closure of the sanitary landfill facility.

(b) The Fund shall be strictly liable for all direct and indirect damages proximately resulting from the improper operation or improper closure of any sanitary landfill facility. The Fund shall not be liable for any damages resulting from the proper operation or proper closure of any sanitary landfill facility.

7:1I-1.7 Signatures; certifications

(a) All claims, and all affidavits required under this chapter, shall be signed by the claimant and notarized, as follows:

1. If the claimant or affiant is a corporation, the claim or affidavit shall be signed by a person authorized by a resolution of the claimant's board of directors to sign the document in question. The claimant or affiant shall submit with the document a copy of the resolution of the claimant's board of directors authorizing the person to sign the document. The copy of the resolution shall be certified as a true copy by the secretary of the corporation.

2. If the claimant or affiant is a partnership, the claim or affidavit shall be signed by a general partner of the partnership.

3. If the claimant or affiant is a sole proprietorship, the claim or affidavit shall be signed by the proprietor of the proprietorship.

4. If the claimant or affiant is a municipality, local unit, State, Federal or other public agency, the claim or affidavit shall be signed by a principal executive officer of such entity, the ranking elected official of such entity, or the designee of such principal executive officer or ranking elected official. If the claim or affidavit is signed by a designee, the claimant shall submit with the claim or affidavit a copy of the document authorizing the designee to sign the claim or affidavit.

5. If the claimant or affiant is a natural person, the claim or affidavit shall be signed by the claimant or affiant, provided however, that if the claimant or affiant is a minor, is incompetent as defined under New Jersey law, or is deceased, the claim or affidavit shall be signed by the claimant's parent, guardian, executor, or court appointed representative, as applicable.

(b) All claims, and all affidavits required by this section shall contain the following certification, signed by the person required to sign the claim or affidavit:

"I certify under penalty of law that I have personally examined and am familiar with the information submitted in this document, and that to the best of my knowledge, after diligent investigation including inquiry of those individuals immediately responsible for obtaining the information, the information contained in this claim is true, accurate and complete. I am aware that there are significant civil and criminal penalties, including fines and/or imprisonment, for submitting false information."

7:1I-1.8 Notices and other communications

(a) All claims, notices, requests, and other communications required or permitted under this chapter shall be given in writing and sent by certified mail, return receipt requested or by other means which provides a receipt showing the date of mailing and the date of delivery. All such communications sent to the Department by certified mail shall be sent to the following address:

Department of Environmental Protection and Energy
Environmental Claims Administration
CN 028
Trenton, New Jersey 08625-0028

(b) All such communications sent to the Department by means for which a street address is required by the carrier shall be sent to the following address:

Department of Environmental Protection and Energy
Environmental Claims Administration
506 East State Street
Trenton, New Jersey 08609

(c) All such communications to the claimant shall be sent to the mailing address set forth in the claim under N.J.A.C. 7:1I-3.3(a)3 unless the claimant directs otherwise under N.J.A.C. 7:1I-3.6.

7:1I-1.9 Computation of time

(a) In computing any period of time fixed by or under this chapter, the day of the act or event from which the designated period begins to run is not to be included. The last day of the period so computed is to be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is neither a Saturday, Sunday nor legal holiday.

(b) In computing any period of time fixed by or under any provision of this chapter, "days" shall mean calendar days, unless the provision specifies working days.

SUBCHAPTER 2. CLAIMS GENERALLY

7:1I-2.1 Persons who may submit a claim

Any person claiming to have incurred damages proximately resulting from the improper operation or improper closure of a sanitary landfill facility may submit to the Department a claim for such damages. No subrogee or assignee of a person who has incurred damages may submit a claim. No claim by a subrogee or assignee of a person who has incurred damages shall be eligible for compensation from the Fund.

7:1I-2.2 Burden of proof

(a) No claim shall be eligible for compensation from the Fund unless the claimant shows by a preponderance of the evidence that the claim satisfies all requirements for eligibility under the Act and this chapter, and that the amount of the claim correctly reflects and is reasonable in relation to the damages which the claimant has sustained. No claimant shall be entitled to payment from the Fund unless the claimant shows by a preponderance of the evidence that the damages sustained are a proximate result of the improper operation or improper closure of a sanitary landfill facility.

(b) A claimant shall affirmatively rebut any and all reasons for denial as stated in a Notice of Intent (NOI) to deny pursuant to N.J.A.C. 7:1I-5.4 or a Denial pursuant to N.J.A.C. 7:1I-5.5.

7:1I-2.3 Damages actually incurred; mitigation

(a) A claim shall be ineligible for compensation from the Fund unless the claimant has actually incurred the damages which are the subject of the claim. A claim shall be ineligible for compensation from the Fund to the extent that the damages which are the subject of the claim are contingent or speculative.

(b) A claim shall be ineligible for compensation from the Fund to the extent that the claimant has received compensation from any other source for damages which are the subject of the claim. The claimant shall exercise best efforts to obtain compensation from any other source from which compensation is reasonably likely to be available. The Department may suspend processing of any claim pending the completion of the claimant's efforts to obtain compensation from such other sources. In determining the amount of an award, the Department shall reduce the award by the amount of any prior compensation for the claimed damages received by the claimant, including without limitation, compensation received from insurance policies, court awards, contractual rights, and any other remedies provided under statutory or common law.

(c) Claimants must fully disclose an award or settlement received or sought from any other source within 10 days of receiving compensation or within 10 days of seeking compensation from any other source. Failure to disclose such action shall result in denial of the claim.

(d) A claim involving the purchase and subsequent sale of property near a sanitary landfill facility shall be ineligible for compensation if the claimant knew or reasonably should have known of the potential that damages could result by virtue of purchasing property near the particular sanitary landfill facility in question.

(e) The claimant shall exercise reasonable diligence and ordinary care and take affirmative measures to mitigate or prevent the damages incurred by the claimant from occurring in the first instance or from increasing or being aggravated.

(f) Any costs incurred by the claimant prior to filing of a claim or during the pendency of a claim shall not prejudice the rights of the Department to evaluate the reasonableness of said costs prior to the granting of an award.

7:1I-2.4 Overlapping claims

(a) A claim shall be ineligible for compensation from the Fund to the extent that the Fund has already paid or settled another claim for the same damages.

(b) If two or more claims include an assertion of the same damages, the Department shall apportion payment for such damages among the claimants or exclude certain of the claims from payment. The Department shall base the apportionment or exclusion upon the Department's determination of which claimants have actually incurred the damages in question.

7:1I-2.5 Waiver of damages not set forth in claim

The claimant shall be deemed to have waived any damages which are not set forth in the claim or in any response to the Department's request for information under N.J.A.C. 7:1I-3.3, or in any amendment to such claim or response under N.J.A.C. 7:1I-3.4.

7:1I-2.6 Claims by responsible parties or by owners or operators of a sanitary landfill facility

(a) No responsible party for a particular sanitary landfill facility shall receive compensation from the Fund for damages proximately resulting from the very sanitary landfill facility for which they are a responsible party.

(b) No owner or operator for a particular sanitary landfill facility shall receive compensation from the Fund for damages proximately resulting from the very sanitary landfill facility for which they are an owner or operator.

(c) No person who at any time deposited, disposed or otherwise discarded solid waste on or into any land at a particular sanitary landfill facility shall receive compensation from the Fund for damages proximately resulting from the very sanitary landfill facility at which they, at any time, deposited, disposed or otherwise discarded solid waste. This express prohibition shall particularly apply to any person who at any time hauled or carted solid waste to the sanitary landfill facility in question.

(d) Notwithstanding (b) above, an owner or operator may be eligible for damages if such owner or operator can establish to the satisfaction of the Department that the claim satisfies either of the following requirements:

1. Despite exercising reasonable diligence and intelligence before purchasing or otherwise acquiring or obtaining title to the land, the claimant did not discover until after purchasing or otherwise acquiring or obtaining title to the land, that a sanitary landfill facility is located, has been located, had been located or at any time was located on the subject property, and before purchasing or otherwise acquiring or obtaining title to the land, the claimant conducted a diligent and thorough inquiry into previous ownership and uses of the property. In order for a person to satisfy the requirement to engage in a diligent and thorough inquiry into previous ownership and uses of the property, a person must perform a preliminary

assessment and site investigation in accordance with N.J.S.A. 58:10-23.11g(d)(2)(d) and N.J.A.C. 7:26E-3; or

2. The claimant is a government entity and acquired the property by escheat or other involuntary transfer or by operation of law, and not by an affirmative act such as exercise of the power of eminent domain. If the government entity acquired or obtained title to the property by an affirmative or voluntary act, the standard set forth in (d)1 above shall govern eligibilty of the government entity's claim.

7:1I-2.7 Administrative closure of claims

(a) The Department may, in its discretion, administratively close any claim for which the claimant has:

1. Failed to take actions required by this chapter within 60 days after the claimant was required to take such action; or

2. Failed to respond to a request for information by the Department within the time period set forth in the request.

(b) Administrative closure of a claim is without prejudice. The claimant may reactivate the claim by rectifying the failure under (a)1 or 2 above and making a written request to the Department for reactivation.

(c) Before closing a claim under (a) above, the Department shall send the claimant written notice of the Department's intent to administratively close the claim. The Department shall state in the written notice the reason for the administrative closure, and the procedure to avoid administrative closure under (d) below.

(d) The Department shall administratively close the claim unless:

1. Within 30 days after the claimant's receipt of the notice described in (c) above, the claimant has submitted to the Department an affidavit explaining why the claim should not be administratively closed (which affidavit may include an explanation of why the time allotted to take such action or provide information was insufficient); and

2. The Department determines that the affidavit provides an adequate explanation of why the claim should not be administratively closed.

7:1I-2.8 Relaxation of procedural requirements

(a) Except as provided by (b) below, the Department may relax any of the procedural requirements of this chapter if the Department determines that strict adherence to such requirements would result in unfairness or injustice.

(b) Notwithstanding (a) above, the Department shall not relax procedural requirements of this chapter if such requirements are imposed by the Act, by other applicable State or Federal statutes, or by applicable decision, order or decree of a court of competent jurisdiction.

7:1I-2.9 Imminent hazard

Priority review of claims may occur in cases where the claimant has demonstrated to the Department's satisfaction that extreme hardship or extreme existing or imminent hazard will proximately result from the improper operation or improper closure of the sanitary landfill facility.

SUBCHAPTER 3. CLAIMS PROCEDURE

7:1I-3.1 Time for filing of claims

Claimants shall submit any claims to the Department not later than one year after the date of discovery of damages. With regard to property value diminution claims, damages, if any, are incurred when the property is sold. Claims for property value diminution, therefore, must be filed within one year of sale of the property. If a claimant fails to submit any claim to the Department within such one-year period, the claimant shall be deemed to have waived such claim. Such waiver is with prejudice and shall bar all recourse by the claimant against the Fund for any damages arising out of or related to the improper operation or improper closure of the sanitary landfill facility.

7:1I-3.2 Submission of claim

(a) For the purposes of determining whether a claim has been timely filed pursuant to N.J.A.C. 7:1I-3.1, the following shall apply:

1. If the claimant submits the claim by United States mail, the claim will be deemed filed as of the date of mailing by the claimant. Claims submitted by mail must be sent in accordance with N.J.A.C. 7:1I-1.8; or

2. If the claimant submits the claim via another means of delivery, the claim will be deemed filed as of the date of receipt by the Department.

7:1I-3.3 Contents of claim

(a) Claims shall be typewritten or written legibly in ink, and shall contain the following information:

1. The name of the claimant;

2. The street address of the claimant;

3. The mailing address of the claimant;

4. The telephone number of the claimant during normal daytime business hours;

5. The name, mailing address, telephone number, and relationship to the claimant of any person designated to receive communications from the Department pursuant to N.J.A.C. 7:1I-3.6;

6. Whether the claimant is an individual, general partnership, limited partnership, corporation, local government entity, Federal government entity, or state government entity;

7. A statement that the claimant has actually incurred damages, as such term is defined in N.J.A.C. 7:1I-1.5, that the claimant has not received compensation from any other source for such damages, and that the claimant is not an owner or operator or responsible party in relation to the claim. Such statement need not be specific about the amount or nature of such damages;

8. If the claim is for property value diminution, a statement that the claimant is attempting to sell the subject property. The Department shall deny, without prejudice, a claim for property value diminution which is filed after the effective date of these rules which does not contain this statement. The claimant may again file the claim upon commencing efforts to sell the subject property;

9. In accordance with N.J.A.C. 7:1I-2.3(d), a statement that the claimant did not know of the existence of the sanitary landfill facility and did not know, nor reasonably could have known, of the potential that property value diminution could result by virtue of purchasing property near the particular sanitary landfill facility in question; and

10. If the claim is for property value diminution and is made pursuant to N.J.A.C. 7:1I-4.8, all documents required by N.J.A.C. 7:1I-4.8 are to be submitted with the claim, including a statement that the claimant has contracted to sell or has sold the subject property and that the claimant will allow the Department or its agents access to the property if claimant still maintains title to the property. If the property has not been sold, claimant must submit within 10 days of the signing of a binding agreement of sale a copy of the contract of sale to allow adequate time for the Department to schedule an appraisal.

(b) The claimant shall submit to the Department the following types of information requested by the Department:

1. The location of the sanitary landfill facility which the claimant believes to be the proximate cause of the damages incurred, including the name of the site, the street address, the municipality, and the county, including without limitation the following:

i. Whether any person, or owner or operator of the sanitary landfill facility has admitted responsibility for the damages claimed or for the condition from which the claim arose, or liability for the amount of damages for which the claim is being made;

ii. If any such person has admitted responsibility or liability pursuant to (b)1i above, the names of such persons and the nature of such statements or admissions; and

iii. Whether the claimant filed a claim against the sanitary landfill facility's Environmental Impairment Liability Fund established pursuant to N.J.S.A. 13:1E-109;

2. A description of any damage to real property located thereon, including without limitation the following:

i. The date on which the damage occurred;

ii. The precise location of the damaged real property, including the street address, the tax lot and block, the municipality, and the county;

iii. A description of the predominant use of the damaged real property;

iv. A detailed description of the damage to the real property;

v. An estimate for the cost to remedy the damage, and the name, address and qualifications of the person making the estimate; and

vi. A description of the claimant's interest in the damaged real property, and documents evidencing such interest. Documents evidencing fee title to the damaged real property shall include an affidavit of title executed by the claimant, together with either a copy of the recorded deed conveying title to the claimant, or an owner's title insurance policy insuring the claimant's interest in the property. Documents evidencing a leasehold interest in the property shall include a copy of the lease for the property, together with an affidavit of the claimant stating that the lease is in full force and effect;

3. A description of any damage to personal property located thereon, including without limitation:

i. The date or dates on which the damage occurred;

ii. The location of the personal property at the time the damaged occurred;

iii. A description of the personal property which was damaged;

iv. A description of the damage;

v. The original cost paid by the claimant for the damaged personal property;

vi. The date the claimant acquired the damaged personal property;

vii. Evidence of the claimant's ownership of the damaged personal property;

viii. An estimate of the cost of repairing the damage to the personal property, and an estimate of the value of the damaged personal property as of the time of the damage;

ix. The name, address and qualifications of any persons who prepared the estimates required by (b)2viii above; and

x. The location at which the Department's designee can inspect the damaged personal property;

4. A detailed description of the facts known to the claimant which support the claim, such as the facts which lead the claimant to believe that the improper operation or improper closure of the sanitary landfill facility cause the damages suffered by the claimant;

5. The names and addresses of any witnesses known to the claimant who may have knowledge concerning the improper operation or improper closure, threatened damage, or damage caused by the sanitary landfill facility;

6. The names of any public agencies (including without limitation any local or state police or any other local, county, state, interstate or Federal agencies) who have investigated the improper operation or improper closure activities and, if known to the claimant, the names of the persons who conducted the investigations on behalf of such agencies;

7. If any of the damaged real or personal property or any of the asserted lost income may be covered by any insurance policy or policies, or other financial agreement or instrument under which compensation is reasonably likely to be available, claimant shall exercise best efforts to obtain compensation from such sources for the damages sustained in accordance with N.J.A.C. 7:1I-2.3(b), and shall provide as proof of such action the following information:

i. The name and address of the insurance carrier which issued the policy, or issuer of the other financial agreement or instrument;

ii. The policy number or other applicable reference number;

iii. A copy of the certificate of insurance or other financial agreement or instrument; and

iv. Copies of any correspondence between the insurance carrier or issuer of the other financial agreement or instrument and the claimant or claimant's representatives concerning the damages claimed;

8. The names and addresses of any persons other than the Fund (including without limitation insurance companies) against whom the claimant has asserted a claim;

9. Whether the claimant has received or agreed to receive any compensation from any person in connection with the damages claimed, and the details of any such compensation or agreement to receive compensation;

10. A description of any action taken to repair, restore or replace damaged real or personal property, including without limitation the following:

i. The name and address of the person who has taken such action; and

ii. The cost of such action;

11. If the claimant asserts any personal injury damages including medical expenses incurred and income lost as a result thereof, the claim shall include the following information:

i. The total amount of the claimed loss of income;

ii. The period of time during which the claimant asserts that the loss of income has occurred;

iii. If the claimant asserts that the loss of income has occurred over a period exceeding 12 months, a breakdown of the loss of income by three-month periods, with the first such period commencing on the date of discovery;

iv. A detailed description of the method employed by the claimant in calculating the claimed loss of income;

v. A statement of whether all income, sales and other accounting and financial information supporting the claim is available for inspection, copying and audit by the Department;

vi. If any of the information described in (b)11v above is not available for inspection, copying and audit, an explanation of why such information is unavailable for such purposes;

vii. With respect to any of the information described in (b)11v above, which is available for inspection, copying and audit, a description of where and when the Department can obtain access to such information;

viii. If any of the information described in (b)11i through vii above has been audited, certified or reviewed by a certified public accountant, the name, address, and telephone number of such accountant, and the date of such audit, certification or review. If such information has been audited, the claimant shall attach copies of all audited statements and the auditor's reports;

ix. A specific statement as to the nature of the health injuries and how the health injuries are related to the improper operation or improper closure of the sanitary landfill facility in question; and

x. Detailed records substantiating the personal injuries; effects or damages suffered by the claimant including any medical records, prognosis statements, and documentation indicating the monetary value of medical attention;

12. If the claimant is a limited partnership, the names and addresses of all general partners;

13. If the claimant is a general partnership, the names and addresses of all partners;

14. If the claimant is a corporation, the names and addresses of all directors and of all officers;

15. Any other information which the claimant believes to be relevant to the claim; and

16. Any other information which the Department deems necessary to process the claim.

(c) Any documents supporting the claimant's assertion of costs incurred in ameliorating the damage resulting from the improper operation or improper closure of a sanitary landfill facility shall be presented as follows:

1. The claimant shall submit a compilation of all such costs, stating the aggregate amount of the costs incurred; and

2. The claimant shall submit a breakdown of the aggregate costs incurred, stating which portion of the aggregate cost is attributable to ameliorating damage resulting from the improper operation or improper closure of the sanitary landfill facility, and which portion is not.

(d) The claimant shall submit all bills, invoices, receipts and other documentation in an orderly fashion, accompanied by an index and/or a summary if the Department determines that an index or summary would assist in the organized and expeditious processing of the claim.

(e) The Department may administratively close the claim pursuant to N.J.A.C. 7:1I-2.7 for failure to provide information under this section.

7:1I-3.4 Amendment of claim

(a) A claimant may amend a claim, or a response to the Department's request for information, with respect to the nature or extent of the damages, the cause of the damages, the amount of the claim,

or any other information relevant to the claim, until the occurrence of the earliest of the following:

1. The approval of the claim by the Department;
2. The denial of the claim by the Department; or
3. The agreement to a settlement among a claimant and one or more owners or operators or other persons in connection with the sanitary landfill facility which is the subject of the claim.

7:1I-3.5 Consent to inspection; investigation

(a) Submission of a claim shall constitute consent by the claimant to allow the Department, and other persons designated by the Department:

1. To inspect all documents and property relating to his or her claim for damages including, but not limited to:
   i. Financial, medical, employment and property records;
   ii. Insurance policies; and
   iii. Damaged real and personal property;
2. For all information submitted pursuant to N.J.A.C. 7:1I-3.3, to copy and audit the information; and
3. To enter onto any property to which the claimant has the right to grant access, or to which the claimant has the right to compel another person to grant access. Any cost which the claimant incurs in compelling such access shall be borne solely by the claimant and shall not constitute a compensable damage payable by the Fund.

(b) In investigating claims for personal injuries, the Department may direct a medical examination of the claimant by an independent physician selected by the Department. The claimant shall present himself or herself to the physician selected at the time and place designated by the physician.

1. A written report of such examination shall be filed by the examining physician with the Department and a copy mailed by the Department to the claimant; and
2. If the Department has directed a medical examination by a physician selected by the Department, such physician's fee shall be paid by the Department from the Fund.

7:1I-3.6 Communication with claimant or representative

The Department will direct all communications in connection with the claim to the person who signed the claim, unless the claimant submits to the Department a written statement, signed by the person required to sign the claim, designating a representative to receive communications from the Department.

7:1I-3.7 Notice to owner or operator

When, in the opinion of the Department, the claim is complete for payment pursuant to N.J.A.C. 7:1I-2.2 and 3.3, the Department shall notify the owner or operator of the sanitary landfill facility by mailing a notice of the claim by certified mail, return receipt requested, to such owner or operator. In the case of multiple, related claims (series claims), the Department will notify the owner or operator of the sanitary landfill facility of the first claim of the series only. This notification will include an estimate of the approximate number of claims expected in that series if known, and will give notice that copies of all further claims must be requested in writing.

SUBCHAPTER 4. PROPERTY VALUE DIMINUTION CLAIMS

7:1I-4.1 Extent of eligibility

Claims for diminution of property value shall be eligible for compensation from the Fund only to the extent that the subject property has been sold and such diminution proximately results from the improper operation or improper closure of a sanitary landfill facility. A diminution of property value may be deemed attributable to the improper operation or improper closure of a sanitary landfill facility notwithstanding the lack of any physical intrusion resulting from the sanitary landfill facility onto the subject property.

7:1I-4.2 Requirements for eligibility

(a) Except for claims settled under N.J.A.C. 7:1I-4.6 or 4.7, claims for diminution of property value are not eligible for compensation by the Fund unless the claimant has sold the subject property and the Department determines that the claimant's sale of the subject property was in good faith, based upon the appraisals made pursuant to N.J.A.C. 7:1I-4.3 and the information submitted pursuant to N.J.A.C. 7:1I-4.5.

(b) Within 30 days after filing the claim, the claimant shall list the subject property for sale with one or more licensed real estate brokers who are members of a multiple listing service (or its commercial equivalent, for nonresidential property). The claimant shall so list the subject property for sale continuously, until entering into an agreement for the sale of the subject property; provided however, that discontinuances made necessary by the claimant's good faith choice to list the subject property with another broker shall not be deemed to violate this requirement. One discontinuity of less than 14 days shall be presumed to be in good faith.

7:1I-4.3 Appraisal of subject property

(a) After the claimant has elected under N.J.A.C. 7:1I-4.9(a)1 to pursue the claim, or in the case of a new claim filed after the operative date of this chapter, the Department shall obtain appraisals of the value of the subject property. The claimant shall notify the Department of the sale, in writing, within 10 days of signing a binding agreement of sale in order to allow the Department sufficient time to have an appraisal completed before settlement. The appraisals shall be as of the time of the sale of the subject property (or, for claims under N.J.A.C. 7:1I-4.6 or 4.7, as of the date the Department issues an NOI to pay). One such appraisal shall state the value of the subject property as affected by the sanitary landfill facility (unless the Department elects not to obtain such appraisal, pursuant to N.J.A.C. 7:1I-4.3(b)), and one appraisal shall state the value of the subject property absent the effect of the sanitary landfill facility. The appraisals may, in the Department's discretion, be based upon one or more of the following factors:

1. Sales of comparable properties in the immediate area;
2. Income generated by the subject property;
3. Replacement cost of the subject property; and/or
4. Such other factors as are ordinarily considered by real estate appraisers who are members of the Appraisal Institute or who are licensed or certified to perform real estate appraisals in New Jersey.

(b) The Department may elect not to obtain an appraisal of the subject property as affected by the sanitary landfill facility if the Department determines in its discretion that there is insufficient information to obtain a meaningful appraisal of the subject property reflecting the effect of the sanitary landfill facility. Without limiting the discretion of the Department under this subsection, the Department may determine that there is insufficient information if fewer than three comparable properties which have been affected by the sanitary landfill facility have been sold as of the date on which the claim is filed.

7:1I-4.4 Valuation of a claim

(a) If the Department has obtained appraisals pursuant to N.J.A.C. 7:1I-4.3(a), the amount of the claim eligible for compensation from the Fund shall be equal to the difference between (a)1 and (a)2 below, adjusted in accordance with (c) below:

1. The appraised value of the subject property determined pursuant to N.J.A.C. 7:1I-4.3(a), excluding the effect of the sanitary landfill facility on such value; and
2. The greater of:
   i. The appraised value of the subject property determined pursuant to N.J.A.C. 7:1I-4.3(a), reflecting the effect of the sanitary landfill facility on such value; or
   ii. The price actually obtained by the claimant upon the sale of the subject property, without closing adjustments.

(b) If, pursuant to N.J.A.C. 7:1I-4.3(b), the Department has elected not to obtain an appraisal of the subject property as affected by the sanitary landfill facility, the amount of the claim eligible for compensation from the Fund shall be equal to the difference between (b)1 and (b)2 below, adjusted in accordance with (c) below:

1. The appraised value of the subject property determined pursuant to N.J.A.C. 7:1I-4.3(a), excluding the effect of the sanitary landfill facility on such value; and
2. The price actually obtained by the claimant upon the sale of the subject property, without closing adjustments.

(c) The Department may, in its discretion, adjust the amount determined pursuant to (a) or (b) above by considering other in-

formation available to the Department which supports a conclusion that the amount determined pursuant to (a) or (b) above does not accurately reflect the diminution in the value of the subject property resulting from the improper operation or improper closure of the sanitary landfill facility. Such information may include, but is not limited to, any of the following:

1. Information concerning sales of comparable properties considered in establishing an appraisal pursuant to N.J.A.C. 7:1I-4.3(a), indicating that factors other than the sanitary landfill facility affected the sale prices of such properties. Such information may include, without limitation, the prices of comparable properties within and outside the area in which the sanitary landfill facility may have affected real property values; general market conditions; the time elapsed between listing for sale and execution of an agreement of sale for comparable properties within and outside the area in which the sanitary landfill facility may have affected real property values; and specific terms of the agreements of sale (such as financing terms, personal property included in the sale, and apportionments of closing costs);

2. Information concerning sales of comparable properties considered in establishing an appraisal pursuant to N.J.A.C. 7:1I-4.3(a), indicating that such properties have characteristics which distinguish them from the subject property, and which affect the values of such properties;

3. Information concerning the sale of the subject property, indicating that the difference between the sale price and the appraised value of the property reflected factors other than the sanitary landfill facility. Such information may include, but is not limited to, the time elapsed between listing of the subject property for sale and execution of an agreement of sale; the length of time the subject property was offered for sale, the nature and number of any offers to purchase the subject property; the difference between the initial listing price and the sale price; the number and extent of intermediate reductions in the listing price; specific terms of the agreement of sale for the subject property (such as financing terms, personal property included in the sale and apportionments of closing costs); data concerning the real estate market generally at the time of the sale of the subject property; and other evidence of the good faith nature of the sale required to be submitted under N.J.A.C. 7:1I-4.5; and

4. The effect of the completion of the construction phase of the sanitary landfill facility remediation or of other amelioration of the damages resulting from the improper operation or improper closure of the sanitary landfill facility.

7:1I-4.5 Evidence of good faith sale

(a) Except as provided in N.J.A.C. 7:1I-4.7 and 4.8, within 10 days after the signing of a binding agreement of sale and the closing of the sale for the subject property, the claimant shall submit the following documents to the Department:

1. Copies of all listing agreements for the sale of the subject property;

2. Copies of all written offers to purchase the subject property;

3. A copy of the contract of sale of the subject property;

4. Copies of all settlement statements, including, without limitation the Settlement sheet(s) required by the Real Estate Settlement Procedures Act (RESPA), 12 U.S.C.A. 2601 et seq. and the HUD-1 Uniform Settlement Statement form if required by 24 CFR 3500.8;

5. A copy of the deed conveying the subject property together with a copy of the transmittal letter forwarding the deed to the county clerk or register of deeds and mortgages for recording;

6. An affidavit by the claimant, signed by the person required to sign the claim and certified in accordance with N.J.A.C. 7:1I-1.7, stating the following:

i. The sale price of the subject property without closing adjustments;

ii. That neither the claimant nor any person not listed on the settlement statements has received any money or other compensation from any person in connection with the subject property, except as set forth on the settlement statements; and

iii. That the documents submitted pursuant to (a)1 through 5 above are delivered in connection with the sale of the subject property; and

7. An affidavit by the claimant's realtor, stating the following:

i. That the realtor is a member of a multiple listing service, and listed the property for sale with a multiple listing service (or its commercial equivalent, for claims involving commercial property or other properties not normally offered for sale through a multiple listing service);

ii. The period of time the subject property was offered for sale, and the period of time the property was listed for sale with the multiple listing service;

iii. The initial listing price;

iv. All changes in the listing price, and the dates of such changes;

v. A record of all inquiries received from potential purchasers regarding the subject property, and of all showings or open houses held in the course of offering the subject property for sale, including the names and addresses of all persons who inquired about the subject property, were shown the subject property, or attended open houses at the subject property, and a description of the responses of these persons to the subject property; and

vi. A record of the amount and date of each offer made for the purchase of the subject property.

(b) A determination by the Department that the claimant arrived at the sale price in good faith shall not preclude the Department from determining that any other aspect of the sale of the subject property was not in good faith.

(c) The Department may deny the claim or adjust the amount eligible for compensation, if based upon the evidence required under (a) above, the Department determines that any aspect of the sale of the subject property was not in good faith.

7:1I-4.6 Settlement based upon legal inability to sell the subject property

(a) If, solely as a result of the improper operation or improper closure of a sanitary landfill facility, the claimant is legally unable to sell the subject property (for example, if a certificate of occupancy cannot be issued for the subject property as a result of the sanitary landfill facility, and the subject property is located in a municipality in which a certificate of occupancy is required for the sale), the Department may, in its discretion, offer to settle the claimant's claim against the Fund in accordance with this section.

(b) If the Department elects to settle a claim pursuant to this section, the Department shall determine the amount of the claim eligible for compensation pursuant to N.J.A.C. 7:1I-4.4. An offer by the Department to settle the claim shall be in such amount.

(c) The making, acceptance or rejection of such settlement offer pursuant to (b) above shall be in accordance with N.J.A.C. 7:1I-5.4.

(d) As a condition of the settlement of the claim pursuant to this section, the claimant shall cause all persons having an ownership interest in the subject property (including without limitation any dower or courtesy interest preserved pursuant to N.J.S.A. 3B:28-1) to execute, acknowledge and deliver to the Department a document, in recordable form, granting to the Fund a lien on the subject property securing repayment of the full amount of the settlement. The Department shall forward such document to the county clerk or register of deeds and mortgages of the county in which the subject property is located. Such document shall be prepared and recorded at the claimant's expense. This lien shall serve as a basis for reimbursement to the Fund of any excess payments made in settlement.

(e) The Department shall execute, acknowledge and deliver to the claimant a discharge of the lien upon payment of the following amount (provided, however, that if the payment amount calculated below is less than zero, the Department shall execute, acknowledge and deliver the discharge of the lien upon the claimant's written request, without the payment of any money; and provided further, that if the payment amount calculated below exceeds the amount of the settlement, the Department shall execute, acknowledge and deliver the discharge of the lien upon repayment of the settlment amount by the claimant, plus interest at the rate for post-judgment interest established in the Rules Governing the Courts of the State of New Jersey, as such rate is in effect as of the date of the settlement):

$$\text{Payment amount} = SP - (AV - S)$$

where:

1. SP equals the sale price of the subject property, as adjusted pursuant to the criteria listed in N.J.A.C. 7:1I-4.4(c), if the Department determines that the actual sale price does not accurately reflect the diminution in the value of the subject property proximately resulting from the improper operation or improper closure of the sanitary landfill facility;

2. AV equals the appraised value of the subject property, absent the effects of the improper operation or improper closure of the sanitary landfill facility, as adjusted under N.J.A.C. 7:1I-4.4(c); and

3. S equals the amount of the settlement made pursuant to this section.

7:1I-4.7 Settlement when emergency relocation is necessary

If the Department determines, in its discretion, that environmental conditions at the subject property which result from the improper operation or improper closure of a sanitary landfill facility create a substantial risk of an imminent health or safety hazard to the occupants of the subject property, the Department may suspend any or all of the requirements of N.J.A.C. 7:1I-4.2, 4.3, 4.4 and 4.5 and may immediately award compensation to enable the occupants of the property to relocate temporarily or permanently.

7:1I-4.8 Contract for sale of property entered into before filing of claim

(a) If a claimant has entered into a contract for the sale of property before filing a property value diminution claim with respect to such property, the Department may, in its discretion, settle such a claim in accordance with this section.

(b) Claims made pursuant to this section shall be eligible for compensation only to the extent provided in N.J.A.C. 7:1I-4.1, and only if the subject property satisfies the eligibility requirements set forth in N.J.A.C. 7:1I-4.2.

(c) Subject to the limitation in N.J.A.C. 7:1I-4.1, the Department shall determine the amount of the settlement offer pursuant to N.J.A.C. 7:1I-4.4.

(d) Together with the claim (or, if the claim is made before closing of the sale of the subject property, within 10 days after closing), the claimant shall submit to the Department all documents required pursuant to N.J.A.C. 7:1I-4.5; provided, however, that the Department may in its discretion, refrain from requiring submission of the documents normally required under N.J.A.C. 7:1I-4.5(a)1 and (a)7.

7:1I-4.9 Suspension of claims

(a) The Department shall send notice of the requirements of this chapter to each claimant who filed a property value diminution claim before the effective date of this chapter. Within 60 days after receipt of such notice, each claimant shall notify the Department of his or her election to:

1. Pursue the claim;

2. Suspend the claim for the period provided in (c) below; or

3. Withdraw the claim.

(b) If a claimant fails to notify the Department of his or her election under (a) above, the claimant shall be deemed to have suspended the claim for the period provided in (c) below.

(c) All claims suspended pursuant to (a) or (b) above will remain in suspension until one of the following occurs:

1. The Department receives written notice from the claimant, stating that the claimant desires to reinstate the claim; or

2. The claimant receives notice from the Department, stating that the remediation or proper closure of the sanitary landfill facility has been completed to the satisfaction of the Department, and that the Department is therefore denying the claim; provided, however, that if the Department has required as a condition of its satisfaction that a restriction running with the subject property be recorded with the applicable county clerk or register of deeds, the claimant may make a claim for diminution resulting from such restriction in accordance with the requirements of this chapter.

(d) At any time during the period of suspension under (c) above, a claimant may request reinstatement of the claim by written notice to the Department.

(e) At the end of the suspension period provided in (c) above, the claim will be automatically reactivated, unless the claimant has previously withdrawn the claim.

(f) The Department may, in its discretion, reactivate a claim suspended under N.J.A.C. 7:1I-2.3(b) upon the conclusion of litigation or negotiations between the claimant and any owner or operator or any other responsible party, which litigation or negotiations concerns such damages. For the purpose of this subsection, litigation or negotiations shall be deemed to have concluded upon the occurrence of any of the following: a complete settlement of the ligitation or matter; or the entry of a settlement, judgment or order completely resolving the litigation or matter, followed by the expiration of time allotted to appeal or otherwise challenge such settlement, judgment or order.

(g) Upon reactivation of a suspended claim:

1. The Department shall confirm the reactivation by written notice to the claimant;

2. The claim will be processed in accordance with this chapter; and

3. Within 30 days after receiving notice of the reactivation, the claimant shall list the subject property for sale with one or more licensed brokers who are members of a multiple listing service (or its commercial equivalent, for claims involving commercial property or other properties not normally offered for sale through a mulitple listing service).

(h) Upon the claimant's second suspension of the claim, the Department shall dismiss the claim, without prejudice. If the claimant subsequently files a new claim for the same damages contained in the original dismissed claim, the new claim will be deemed to have been filed as of the date of filing of the original dismissed claim.

SUBCHAPTER 5. SETTLEMENT AND DETERMINATION OF CLAIM

7:1I-5.1 Settlement of claim with owner, operator or other person

(a) At least two weeks prior to any private settlement with any owner or operator or other person, the claimant shall notify the Department by certified mail of the terms of the settlement.

(b) If the claimant privately settles with any owner or operator or other person in connection with the sanitary landfill facility in question, any payment the claimant receives as a result of that settlement shall be deducted from the amount of compensation awarded by the Department regarding the claimant's damages; provided, however, that if the settlement terms release any owner or operator from further liability, the settlement shall be an absolute bar to any claim for damages from the Fund.

7:1I-5.2 Actual real or personal property damage

If the claimant submits all evidence required by N.J.A.C. 7:1I-3.3, and if, after verification of the reasonableness of all estimates and receipts submitted, the Department is satisfied with the evidence submitted, the Department shall issue a Notice of Intent pursuant to N.J.A.C. 7:1I-5.4.

7:1I-5.3 Personal injuries

If the claimant submits all evidence required by N.J.A.C. 7:1I-3.3, and if, after verification of the reasonableness of receipts and opinions supplied, the Department is satisfied with the evidence submitted, the Department shall issue a Notice of Intent pursuant to N.J.A.C. 7:1I-5.4.

7:1I-5.4 Notices of Intent

(a) The Department shall issue a Notice of Intent (NOI) to deny with respect to any claim which, on its face, does not contain information sufficient to support a determination that the claim is eligible for compensation from the Fund. The Department shall issue a Notice of Intent (NOI) to pay with respect to any claim which contains sufficient information to support a determination that the claim is eligible for compensation from the Fund. The Department shall send the claimant the NOI by certified mail, return receipt requested.

(b) The claimant shall either accept the NOI or may contest the NOI by submitting to the Department additional evidence in support of the claim, and evidence that any material fact set forth in the NOI is incorrect. Legal arguments will not be accepted. The claimant

shall submit such evidence within 30 days after the date on which the claimant received the NOI; provided however, that if the claimant has refused delivery of the NOI, the claimant shall submit such evidence 30 days after the date the Department mailed the NOI.

(c) In the case of an NOI to deny, if after reviewing the evidence submitted pursuant to (b) above, the Department determines that the claim does not clearly fail to satisfy the requirements for eligibility for compensation from the Fund, then the Department shall withdraw the NOI and reconsider the claim. However, if after reviewing the evidence submitted pursuant to (b) above, the Department determines that the claim does clearly fail to satisfy the requirements for eligibility for compensation from the Fund, then the Department will process the claim in accordance with N.J.A.C. 7:1I-5.5. The claimant may contest the Department's final decision by proceeding in accordance with N.J.A.C. 7:1I-5.6.

(d) In the case of a NOI to pay, if after reviewing the evidence submitted pursuant to (b) above, the Department determines that the claimant has clearly demonstrated its entitlement to a payment greater than the amount contained in the NOI to pay, then the Department shall make a new offer of payment with regard to the claim. However, if after receiving the evidence submitted under (b) above, the Department determines that the claimant has not clearly demonstrated its entitlement to a payment greater than the amount contained in the NOI to pay, then the Department shall issue a final decision on the claim. If the claimant wishes to contest the Department's final decision, the claimant shall proceed in accordance with N.J.A.C. 7:1I-5.6.

7:1I-5.5 Denials

(a) The Department shall deny the claim after the expiration of the 30-day period allotted under N.J.A.C. 7:1I-5.4(b), if the claimant fails to submit any evidence to the Department within the 30-day period.

(b) The Department shall deny any claim if, after reviewing the evidence submitted pursuant to N.J.A.C. 7:1I-5.4(b), the Department determines that the claim clearly fails to satisfy the requirements for eligibility for compensation from the Fund.

(c) If the Department denies the claim pursuant to this section, the Department shall prepare a written statement setting forth the denial and the reasons therefor. The Department shall send the claimant a copy of the final decision by certified mail, return receipt requested.

7:1I-5.6 Adjudicatory hearings

(a) A claimant may contest a final claim decision by requesting a hearing before the Office of Administrative Law. The claimant shall make the request in writing within 30 days after receiving the Department's written statement under N.J.A.C. 7:1I-5.5(c); provided, however, that if the claimant has refused delivery of the Department's final decision, the claimant shall make the request for a hearing within 30 days after the date of mailing of the final decision. Failure to request a hearing before the expiration of such 30-day period shall operate as a waiver of any right to have the claim submitted to a hearing.

(b) A request for a hearing under (a) above shall contain the following information:

1. A denial of each fact disputed by the claimant which the Department has asserted in the final claim decision. The claimant's denial shall fairly meet the substance of the disputed facts, and shall contain assertions of the facts as the claimant believes them to be;

2. If the claimant asserts that, based upon the facts asserted in the Department's final claim decision, the Department's decision is improper as a matter of law, a specific explanation of the legal basis for that assertion;

3. Copies of written documents which the claimant is relying upon to support the request, provided, however, that if the claimant has previously submitted such documents to the Department, a specific reference to such documents will be sufficient;

4. An estimate of the time required for the hearing; and

5. A request, if necessary, for a barrier-free hearing location for physically disabled persons.

(c) If the claimant does not submit the information required under (b) above within the time allotted under (a) above, the Department, after proper notice to the claimant, may deny the request.

(d) The Department may require that the claimant submit additional information beyond that required under (b) above, if the Department determines that such information is necessary to provide the Department with adequate notice of the specific factual or legal bases for the claimant's objections to the final claim decision.

(e) A request for an adjudicatory hearing shall be filed with the Department at the following address:

Office of Legal Affairs
ATTENTION: Adjudicatory Hearing Requests
Department of Environmental Protection and Energy
CN 402
Trenton, New Jersey 08625-0402

All such communications regarding adjudicatory hearings for which a street address is required shall be sent to the following address:

Office of Legal Affairs
ATTENTION: Adjudicatory Hearing Requests
Department of Environmental Protection and Energy
401 East State Street
Trenton, New Jersey 08609

(f) If the Department grants the hearing request, the Department shall file the request for a hearing with the Office of Administrative Law. The hearing shall be held before an administrative law judge 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.

SUBCHAPTER 6. CONDITIONS OF PAYMENT

7:1I-6.1 Payment of claim

(a) Except as provided in (b) below, the Department shall make claim payments in a single lump sum payment.

(b) The Department may bifurcate multiple damages filed in a single claim and make payments separately thereon.

(c) In the event that the total amount of claims awarded exceeds the current balance of the Fund, each award shall be paid, without interest, on a prorated basis over time until the awards are paid in full. Claims initially paid on a prorated basis will be satisfied in full before any payments are made on new claims.

7:1I-6.2 Conditions of payment

(a) No payment of any damages from the Fund shall be made unless the Department acquires, by subrogation, all rights of the claimant to recovery of such damages from an owner or operator or any other responsible party concerning the damages resulting from the improper operation or improper closure of a sanitary landfill facility.

1. The claimant shall not prejudice such subrogation rights in any manner;

2. The claimant shall cooperate fully with the Department in the preparation of a case for trial, should the Department commence a civil action to recover any amount awarded; and

3. The claimant shall allow the Department to join his or her claim with as many claims as the Department may have against any person in any civil action commenced to recover any amounts awarded.

(b) No payment of any damages from the Fund shall be made unless the claimant executes a written release of all damages occurring prior to execution of the release except those damages which could not reasonably have been discovered prior to signing the release. The release shall satisfy all conditions precedent to payment of the claim required by this chapter.

(c) In all claims concerning property damage where the Department has settled or intends to settle the claims, the claimant shall include in the agreement of sale and in the deed, a covenant which shall run with the land indicating that the claimant has negotiated with the Department for specific enumerated damages and that these

damages have been satisfied. In the case of property value diminution claims, such covenant shall state that further payment from the Fund for similar damage is barred.

(a)

OFFICE OF AIR QUALITY MANAGEMENT

Enhanced Inspection and Maintenance Program

Notice of Proposal of Amendments: N.J.A.C. 7:27-15.4, 7:27A-3.10, and 7:27B-4.5 and 4.6

Notice of Proposal of New Rule: N.J.A.C. 7:27B-4.9

DEPE Docket Number: 56-93-10/340.

Take notice that the Department of Environmental Protection and Energy (the Department) will be proposing amendments and new rules at N.J.A.C. 7:27-15 (Subchapter 15, Control and Prohibition of Air Pollution from Gasoline-Fueled Motor Vehicles), N.J.A.C. 7:27A-3.10 (Civil Administrative Penalties for Violations of Rules Adopted Pursuant to the Act), and N.J.A.C. 7:27B-4 (Subchapter 4, Air Test Method 4: Testing Procedures for Motor Vehicles), its rules governing standards, corresponding penalties, and testing procedures for the inspection of motor vehicles. This proposal will be published in the New Jersey Register on December 6, 1993.

This proposal will supplement the amendments and new rules proposed by the Department on August 2, 1993 at 25 N.J.R. 3322(a). On August 2, 1993, the Department of Law and Public Safety, Division of Motor Vehicles (the DMV) also published a related pre-proposal of new rules at N.J.A.C. 13:20-43 (Subchapter 43, Enhanced Motor Vehicle Inspection and Maintenance Program) at 25 N.J.R. 3418(a). The Department and the DMV jointly held a public hearing on September 17, 1993 on the proposed amendments and new rules and the pre-proposal. These agencies accepted written comment on the proposal and pre-proposal, respectively, until the close of the comment period on September 24, 1993.

The United States Environmental Protection Agency (the EPA) has set forth the performance standard that an enhanced Inspection and Maintenance (I/M) program must meet at 40 C.F.R. 51.351. The goal of the Department and the DMV has been to adopt an enhanced I/M emission test that would meet EPA's performance requirement while yielding a throughput rate of at least 15 vehicles per hour in a biennial inspection program. The EPA had developed a test procedure, the IM240, which, as part of EPA's model program design, met the required performance standard. However, the throughput rate for the IM240 would not have exceeded 12.5 vehicles per hour.

Consequently, the Department's August 2, 1993 proposal set forth two alternative emission testing procedures. Alternative Exhaust Test A is a shortened version of the IM240. Alternative Exhaust Test B is a steady-state loaded test known as the Acceleration Simulation Mode (ASM) 5015.

At the September 17, 1993 public hearing, the EPA announced the release of the finalized version of its "fast-pass/fast-fail" algorithm, which would lead to early termination of the IM240 exhaust emission test and the EPA-recommended purge test for those vehicles which would clearly pass or fail the full 240-second emission test and the purge test. The purge test is performed simultaneously with the IM240 exhaust emission test. As reported by the EPA, application of this algorithm would shorten the EPA's average test time from 240 seconds to approximately 115 seconds and would increase the throughput rate to 20 vehicles per hour. In a letter from Eugene J. Tierney, Chief of the Inspection/Maintenance Section of the Office of Mobile Sources for the EPA, to the states dated September 13, 1993, the EPA has indicated its intent to promulgate regulations to formally adopt the "fast-pass/fast-fail" algorithm, by proposing to amend 40 C.F.R. with a new section, 85.2205(a)(4)-(5).

At the time of the Department's original August 2 proposal, the EPA's "fast-pass/fast-fail" algorithm was in developmental stages at the EPA and unavailable to the Department. The Department's supplemental proposal will set forth at N.J.A.C. 7:27B-4.5 a third alternative exhaust emission test procedure, utilizing the EPA's "fast-pass/fast-fail" algorithm, and will set forth at N.J.A.C. 7:27B-4.6 a third alternative purge test procedure, also utilizing EPA's "fast-pass/fast-fail" algorithm. Over the next few months, the DMV, in conjunction with the Department, will be evaluating the throughput that can be obtained through the use of the IM240 exhaust emission test using this new algorithm in a demonstration lane at the DMV's Wayne inspection facility.

The Department will take into consideration the results of this testing, and findings of any other studies underway relevant to the effectiveness of the EPA-recommended alternative exhaust test procedures or to the effectiveness of the Department's previously proposed Alternative Exhaust Tests A and B. In addition, all data obtained on any of the three alternative purge tests will be considered by the Department. This material, as well as relevant information submitted to the Department as part of the public comment on the August 2, 1993 proposal, will be used by the Department in making the determination as to which of the alternative exhaust and purge test methods to adopt.

Thus, the Department will be, through this supplemental rule proposal, soliciting comments on the EPA-recommended alternative procedures. In addition, the Department is reopening the comment period for N.J.A.C. 7:27B-4.5 as proposed on August 2, 1993, which set forth Alternative Exhaust Tests A and B, and reopening the comment period for N.J.A.C. 7:27B-4.6 as proposed on August 2, 1993, which set forth Alternative Purge Tests A and B. The new and reopened comment periods will close on January 5, 1994. A full description of the Department's previously proposed Alternative Exhaust Tests A and B and Alternative Purge Tests A and B can be found in 25 N.J.R. 3322(a).

A copy of the supplemental proposal of new rules and amendments is currently available and may be requested from Felice Weiner by telephone (609) 777-1345, fax (609) 633-6198, or in writing:

Felice Weiner
Air Quality Rule Development
Office of Policy and Planning
CN 418
401 East State Street
Trenton, New Jersey 08625

A **public hearing** concerning the supplemental proposal will be held on:

Wednesday, December 22, 1993, 10:00 A.M. at:
New Jersey Department of Environmental Protection and Energy
Hearing Room, 1st Floor
401 East State Street
Trenton, New Jersey 08625

The public is invited to present oral comments at the public hearing and to submit written comments, identified by DEPE docket number, by January 5, 1994 to:

Janis Hoagland
Office of Legal Affairs
New Jersey Department of Environmental Protection and Energy
CN 402
Trenton, N.J. 08625-0402

LABOR

(b)

DIVISION OF VOCATIONAL REHABILITATION SERVICES

Rules of the Division of Vocational Rehabilitation Services

Proposed Readoption with Amendments: N.J.A.C. 12:45

Proposed Repeal: N.J.A.C. 12:45-3

Authorized By: Raymond L. Bramucci, Commissioner, Department of Labor.

Authority: N.J.S.A. 34:1-20, 34:1A-3(e), 34:16-20 et seq. and 34 C.F.R. §361.1 et seq.

Proposal Number: PRN 1993-631.

Submit written comments by December 15, 1993 to:

Linda Flores, Special Assistant
External and Regulatory Affairs
Office of the Commissioner
Department of Labor
CN 110
Trenton, New Jersey 08625-0110

The agency proposal follows:

Summary

Pursuant to Executive Order No. 66(1978), N.J.A.C. 12:45, Division of Vocational Rehabilitation Services, was scheduled to expire on May 2, 1993. On April 23, 1993, Governor James Florio waived the sunset provision of Executive Order No. 66(1978) and established December 31, 1993 as the expiration date for the chapter (see 25 N.J.R. 2216(b)).

The chapter on the Division of Vocational Rehabilitation Services sets forth the procedures, standards and criteria used by the Division of Vocational Rehabilitation Services to provide rehabilitation services to individuals with disabilities, as well as the procedures and standards used to defray the costs of transportation of individuals with disabilities who are certified to participate in community rehabilitation programs certified to provide this service by the Department of Labor through the Division of Vocational Rehabilitation Services. The rules in the chapter also establish the requirements designed to ensure that mobility impaired residents of New Jersey who are clients of the Division receive equipment which is functional, safe and durable.

The Department has reviewed these rules, particularly in light of the 1992 Federal amendments to the Rehabilitation Act, P.L. 102-569, and has determined these rules to be reasonable, necessary, adequate, efficient, understandable and generally responsive to the purposes for which they were originally promulgated. However, to ensure compliance with the 1992 Federal amendments to the Act, the rules proposed for readoption in subchapter 1 have been amended to correspond to the Federal amendments, as summarized below.

Only minor revisions are proposed for subchapter 2 and are summarized below. The Department proposes to repeal subchapter 3 since automotive adaptive equipment design, fabrication, installation and vehicle modification requirements are more appropriately set by industry and other standards of the U.S. Veteran's Administration, the Society of Automotive Engineers, the State Division of Motor Vehicles, etc. The following more fully describes the proposed amendments to subchapters 1 and 2.

"Person first" language has been proposed throughout the chapter. Such terms as "the handicapped" or "handicapped individual" have been replaced with "individuals with disabilities" or "individual with a disability." Using language that recognizes that a person with a disability is a person first and that the disability is only one of the person's characteristics should help dissolve the barriers of psychological exclusivity promoted by the personification of disabilities. N.J.A.C. 12:45-1.1 sets forth the purpose and scope of the rules. No substantive changes are proposed to this section.

The greatest number of changes are required in subchapter 1, particularly the definitions section, in order to conform to the 1992 Federal amendments. "Competitive work" has been deleted since the amendments removed restrictions related to numbers of hours worked per week. "Disabled public safety officer" has been replaced by "public safety officer" to be consistent with terminology used in the 1992 amendments. "Eligible" or "eligibility" has been deleted from the definitions since new criteria for eligibility are included under N.J.A.C. 12:45-1.4 as required by the 1992 Federal amendments. "Employability" has been replaced by "employment outcome" to be consistent with terminology used in the 1992 amendments. Emphasis is on placing individuals with disabilities in jobs, preferably competitive jobs in integrated work settings, rather than in making individuals with disabilities employable. "Evaluation of vocational rehabilitation potential" has been replaced by "assessment for determining eligibility and vocational rehabiliation needs since the 1992 Federal amendments establish the presumption" it is presumed that individuals with disabilities have rehabilitation potential. Assessments for determining eligibility and vocational rehabilitation needs emphasize a review of existing data; the obtaining of additional data only if necessary to identify the rehabilitation needs of the individual and to develop the rehabilitation program of the individual; and utilization of the individual as a primary source of information. "Extreme medical risk" has been deleted, as there is, given the Federal amendments, no longer any reference to "extreme medical risk" in the proposed rules.

"Impartial hearing officer" has been amended to conform to the Federal amendments. The new definition of "impartial hearing officer" clarifies that Administrative Law Judges, hearing examiners and employees of public institutions of higher education are not excluded from being impartial hearing officers on the basis of being employed by a public agency. It specifically precludes members of the State Rehabilitation Advisory Council from serving as impartial hearing officers. It should be noted that the Governor is required by Federal mandate to establish the State Rehabilitation Advisory Council by October 29, 1993 and to appoint its members. It is therefore expected that the individuals who will be unable to serve as impartial hearing officers under the amended rules will be identified at the time of adoption of the rules. The new definition also clarifies the impartial hearing officer's need for knowledge of vocational rehabilitation services by including knowledge of the State Plan and the Federal and state rules governing the provision of such services as a requirement and adds the requirement that impartial hearing officers have training with respect to the performance of official duties.

The terms "individual with handicaps" and "individual with severe handicaps" have been changed to "individual with a disability" and "individual with a severe disability" respectively, and the definitions of these terms have been changed to conform to the Federal amendments. The term "individual with a most severe disability" has been added and relates to the number of functional capacities affected as a result of an impairment. The 1992 Federal amendments require each state to define "individual with a most severe disability." The Department proposes to define this category of individuals by minimizing the distinctions between an individual with a disability and an individual with a most severe disability. Hence, the only difference in these two categories lies in the number of functional capacities affected by an impairment. The definition of "physical and mental restoration services" has been deleted, and such services have been incorporated at N.J.A.C. 12:45-1.13, Vocational rehabilitation services. "Rehabilitation engineering" has been replaced by "rehabilitation technology" which includes rehabilitation engineering, assistive technology devices and assistive technology services. "Substantial handicap to employment" has been deleted because, pursuant to the 1992 Federal amendments, it is no longer an eligibility criterion; it has been replaced with "impediment to employment." The former term was part of the eligibility criteria prior to the 1992 Federal amendments, but is no longer used.

"Supported employment" has been changed to conform with the Federal amendments; it is limited to individuals with the most severe disabilities who, because of the nature and severity of their disabilities, need intensive supported employment services or extended services in order to perform work. "Physical and mental disability" has been replaced by "disability." "Community rehabilitation program" has been added to subchapter 1 and a more specific and narrower definition of that term has replaced "sheltered workshop" in subchapter 2. Community rehabilitation programs are eligible for establishment, development and improvement grants to benefit groups of individuals as cited at N.J.A.C. 12:45-1.13(b). Prior to the 1992 Federal amendments, such grants were limited to rehabilitation facilities. The term "rehabilitation facility" was changed to "community rehabilitation program" to include those programs that deliver their services in the community (work sites, homes, along travel routes, etc.) rather than in a facility. Definitions for the terms "personal assistance services," "extended services," "on-going support services," "supported employment services," and "transition services" have been added to subchapter 1 and the term "personal auto" to subchapter 2. The definition of "supported employment services" provides for special circumstances under which the Division may extend supported employment services for more than 18 months and includes circumstances in which there is a reason to believe that an extension would allow the eligible individual to achieve the objectives identified in the individualized written rehabilitation program.

N.J.A.C. 12:45-1.3(f) adds the requirement that eligibility decisions be made within 60 days after the individual has submitted an application to receive services, unless the counselor notifies the individual that exceptional and unforeseen circumstances preclude completing the determination and the individual agrees to an extension of time, or an extended evaluation is required as determined by the counselor.

Attitudinal and technology-related advances are reflected throughout the amendments. There is a presumption that individuals with disabilities can benefit from vocational rehabilitation services in terms of an employment outcome unless the Division can demonstrate by clear and convincing evidence that the individual cannot benefit. Although the "clear and convincing evidence" standard is not new to the legal arena, the application of the standard is new to the vocational rehabilitation context. Inasmuch as the Federal regulations are still pending, the Department proposes to utilize the definition of the standard which appears in Black's Law Dictionary, Centennial Edition (1989-1991), until such time as further guidance is forthcoming from the Federal government. The "clear and convincing evidence" standard raises the required proof for a finding by the Division that the individual with a disability cannot benefit from

vocational rehabilitation services, consistent with the presumption that disabled individuals have rehabilitation potential. These changes are reflected in the eligibility criteria at N.J.A.C. 12:45-1.4, the preliminary assessment at N.J.A.C. 12:45-1.5, the comprehensive assessment rules proposed at N.J.A.C. 12:45-1.6, the extended evaluation rules set out at N.J.A.C. 12:45-1.7 and the certifications of eligibility, extended evaluation and ineligibility contained in N.J.A.C. 12:45-1.8. A statement has been proposed to N.J.A.C. 12:45-1.8 which requires that an extended evaluation to be conducted in those cases in which it appears that an ineligibility decision may be forthcoming based upon the severity of the disability of an individual. This provision is required by the 1992 Federal amendments.

Both the preliminary assessment and comprehensive assessment found at N.J.A.C. 12:45-1.5 and 1.6 stress the use of existing data to expedite the eligibility determination, identify the rehabilitation needs of the individual, develop the rehabilitation program, conserve resources and eliminate duplication of effort.

Proposed amendments to the order of selection for services at N.J.A.C. 12:45-1.9 are made to conform to the Federal requirement that individuals with the most severe disabilities be served first when all eligible individuals with disabilities who apply for services cannot be served. Current Federal policy prohibits states from establishing other priority categories based upon the particular service needs or anticipated cost of services required by an individual. Federal law also requires states to give priority to eligible public safety officers as defined at N.J.A.C. 12:45-1.2.

N.J.A.C. 12:45-1.10 requires that each counselor maintain a case record for each applicant for, or recipient of, vocational rehabilitation services and describes the type of information which is to be included therein. No change is proposed for this section.

N.J.A.C. 12:45-1.11 requires the counselor to develop an individualized written rehabilitation program (IWRP) whenever it is determined that an individual is eligible for vocational rehabilitation services or that an extended evaluation is necessary to determine eligibility, and sets forth the procedures which are to be followed in the development of the IWRP, including monitoring and review. Only two minor changes in language are being made consistent with the Federal mandates.

Proposed amendments to the "contents of the individualized written rehabilitation program (IWRP)" found at N.J.A.C. 12:45-1.12 incorporate the increased consumer involvement and choice in both the development and implementation of the program; the increased emphasis on placement in integrated settings; and the consideration of rehabilitation technology, personal assistance services and post-employment services. N.J.A.C. 12:45-1.12 also reflects a relaxation of the maximum duration of time-limited services and a broadening of sources for extended services for individuals with the most severe disabilities for whom a vocational objective of supported employment has been determined to be appropriate. All of the proposed amendments to N.J.A.C. 12:45-1.12 were made to conform with the 1992 Federal amendments.

N.J.A.C. 12:45-1.13 has been expanded to include personal assistance and transition services, and maintenance has been limited to "additional costs incurred while participating in rehabilitation." The establishment, development or improvement of community rehabilitation programs to benefit groups of individuals must be used to provide services that promote integration and competitive employment, which is a significant departure from the promotion of the extended or sheltered employment programs. Technical assistance and support services to businesses not subject to Title I of the Americans with Disabilities Act and seeking to employ individuals with disabilities have been added as vocational rehabilitation services. All of the changes to N.J.A.C. 12:45-1.13 were made to conform to the 1992 Federal amendments.

N.J.A.C. 12:45-1.14 includes elements required to determine that an indivdiual has been rehabilitated. The requirement that the individual be provided "an evaluation of vocational rehabilitation potential" has been deleted to be consistent with the presumption of rehabilitation potential embraced by the 1992 Federal amendments.

No changes are proposed to N.J.A.C. 12:45-1.15 at this time. This section describes the participation by clients in the cost of vocational rehabilitation services. Federal regulations permit each state to consider the financial need of clients in determining the client's participation in the costs of all vocational rehabilitation services except; assessments for determining eligibility and vocational rehabilitation needs, including vocational rehabilitation services provided during an extended evaluation for purposes of assessment; counseling, guidance, and referral services; and placement services. The section is presently being reviewed and public input will be solicited before any changes are proposed.

The principal changes proposed at N.J.A.C. 12:45-1.16 include the circumstances under which and to whom the Division may release personal information. Federal reviews of Division case records have resulted in a Federal directive that the circumstances under which and to whom personal information may be released by the Division be included in Division policy. While Federal law does not specifically require that these circumstances be detailed in regulations, the Department believes it is in the public interest to describe these circumstances by regulation rather than through internal policy directives. Because of the Federal mandate, however, the Department was unable to solicit input from the public before the rules were proposed. Therefore, the public comments submitted on this sensitive area will be given special attention before adoption of the final rule.

Amendments are proposed at N.J.A.C. 12:45-1.17 regarding the rights of applicants/clients to appeal decisions of the Division and to distinguish between administrative reviews before a Division administrator and fair hearings before an impartial hearing officer. Applicants/clients may request either a review or hearing or both a review and hearing. Fair hearings are required by Federal law. Administrative reviews are proposed for more expeditious and less costly resolution of appeals; however, applicants/clients availing themselves of the administrative review process retain their right to a fair hearing.

It is anticipated that regulations for P.L. 102-569 will be promulgated at the Federal level, at which time additional amendments to this subchapter may be required. It is also hoped that Federal regulations will address the application of the "clear and convincing evidence" standard to ineligibility determinations and the involvement of individuals with disabilities in choosing among alternative services, entities providing such services and methods used to provide or procure such services within the constraints of reasonable fees for necessary services.

As to subchapter 2, only minor revisions were made. N.J.A.C. 12:45-2.1 sets forth the purpose and scope of the subchapter and N.J.A.C. 12:45-2.2 defines the words and terms used in the subchapter. No changes are proposed to these sections.

At N.J.A.C. 12:45-2.3(b), reporting dates were changed to allow community rehabilitation programs to complete their surveys for two six-month periods within the same State fiscal year so that payments can be made from the appropriate appropriation as soon as possible. The proposed reporting dates are August 1 (for the preceding six months of January 1 through June 30) and February 1 (for the preceding six months of July 1 through December 31) instead of June 1 and December 1. The mode of transportation rules were expanded to include personal autos to reflect transportation systems actually used by individuals at N.J.A.C. 12:45-2.2.

The rules governing the method of payment found at N.J.A.C. 12:45-2.4 were changed to insure an equitable distribution of reimbursements proportionate to the individual's costs.

The percentage of an individual's costs which will be reimbursed will be determined by dividing the amount of the total appropriation awarded for travel expenses by the total of all clients' reimbursable costs. This percentage will be applied across the board to all clients so that each client is reimbursed the same percentage of his or her costs in the same fiscal year.

Finally, subchapter 2's instructions for completing the transportation survey (see Appendix A) and the survey itself were simplified to include only that information which is essential for an equitable distribution of funds to eligible individuals.

With regard to subchapter 3, the Department proposes to repeal the subchapter. Subchapter 3, which describes the requirements for vehicle modifications and auto adaptive devices, has been, at best, only informational. The standards contained therein are established by the industry and the Department had attempted to centralize this information. However, the rules are extremely technical and as such are not readily understandable by the consuming public. Moreover, the Department believes that its promulgation of these rules may mislead the public by suggesting that the Department has "approved" these standards, when in fact these rules do not reflect the expertise of the Division, but rather, reflect the standards established by the industry, the U.S. Veteran's Administration, the Society of Automotive Engineers, the State Division of Motor Vehicles, etc. The information contained in the subchapter may be obtained directly from the sources involved and individuals interested in doing so may contact the Division for address information. According-

ly, under these circumstances, the Department has determined that it would be prudent to repeal this subchapter.

Social Impact

The proposed readoption with amendments of the standards, procedures and criteria are designed to govern the provision of vocational rehabilitation services by the Division of Vocational Rehabilitation Services of the Department of Labor. The current proposal has been modified to incorporate the Federal mandates which were adopted in the Rehabilitation Act of 1992, P.L. 102-569. The community of individuals with disabilities, the Department and the general public is expected to benefit by the readoption of standards in this area, particularly the amendments needed to ensure compliance with the Federal government's requirements.

Many of the amendments are proposed to recognize that individuals with disabilities can and do perform meaningful work in integrated settings and that they should play a major role in choosing among alternative goals, objectives, services, entities providing service and methods used to procure services. The recognition of the abilities of individuals with disabilities and their right to make informed choices are reflected throughout the proposed rules by using more respectful "person first" language and presuming that they can benefit from carefully chosen services from within a broader array of services. These changes which are particularly evident in the definitions section (N.J.A.C. 12:45-1.2), the eligibility criteria (N.J.A.C. 12:45-1.4), the assessments (N.J.A.C. 12:45-1.5 and 1.6), the extended evaluation (N.J.A.C. 12:45-1.7), the certifications (N.J.A.C. 12:45-1.8), the contents of the IWRP (N.J.A.C. 12:45-1.12) and the vocational rehabilitation services (N.J.A.C. 12:45-1.13) will directly benefit the individuals with disabilities and will help eliminate barriers faced by people with disabilities. The public and the Department will also benefit by the increased participation of this untapped resource, individuals with disabilities, in community activity and work.

The removal of "an average of at least twenty hours of work per week" from the definition of "competitive work" makes it possible for individuals with the most severe disabilities who cannot reach that minimum average to still participate in supported employment. This change, required by the 1992 Federal amendments, may divert resources to individuals with the most severe disabilities from other eligible individuals with disabilities. As a result the Department may reach fewer individuals; however, those being served require the most extensive services.

Emphasis on employment outcomes and more placements in integrated settings should benefit individuals with disabilities, the public and the Department by making individuals with disabilities more independent and self-supporting. Rehabilitation facilities maintaining segregated programs may be negatively impacted by a reduction in referrals for service.

The presumption that individuals with disabilities can benefit from vocational rehabilitation services reflected at N.J.A.C. 12:45-1.4, 1.5, 1.7, 1.8 and the replacement of the term "evaluation of rehabilitation potential" with "assessment for determining eligibility" will benefit individuals with disabilities. The impact on the public and the Department depends upon the validity of the presumption which is contained in the 1992 Federal amendments. If valid, all segments of society will benefit; if invalid, resources will be expended without achieving employment outcomes for some individuals while others may not be served because of insufficient resources.

Determinations of eligibility will be expedited, thereby benefitting individuals with disabilities, the public and the Department because the Division will be able to use existing data and information obtained from clients from the preliminary assessments, comprehensive assessments and other sections of the subchapter, and implied in the deletion of the evaluation requirement at N.J.A.C. 12:45-1.4. This will eliminate duplication of services and maximize resources.

The addition of the term "individual with a most severe disability" in the definitions, as a condition of supported employment and in the order of selection for services at N.J.A.C. 12:45-1.9 places increased emphasis on providing services to this group of individuals. This group will benefit. Eligible individuals with less severe disabilities may be required to locate supplemental resources and utilize alternative training services outside of the traditional vocational rehabilitation system.

The expansion of the definition of "assistive technology" should benefit individuals with disabilities, the public and the Department by allowing the utilization of more devices and services to improve the functional capacities of individuals with disabilities.

The addition of "personal assistance service" as a vocational rehabilitation service will benefit individuals with severe disabilities. When resources are limited, individuals with less severe disabilities may experience limitations in accessing services and be required to utilize alternative resources provided through agencies and providers outside of the Department.

The addition of "transition services" as a vocational rehabilitation service will benefit students moving from secondary education to post-secondary activities. The provision of transition services will result in the avoidance of any gaps in programming for students. Students, their families, the public and the Department will benefit from this coordinated set of activities.

The application of the "clear and convincing" standard contained in the amendment at N.J.A.C. 12:45-1.7 to determinations of eligibility based upon a determination that an individual cannot benefit from vocational rehabilitation services in terms of an employment outcome will benefit individuals with disabilities by maximizing the opportunity to benefit from vocational rehabilitation services. To the extent additional resources may be needed to meet the standard, this new standard may adversely affect the total pool of individuals able to be served because of limitations in resources; however, the standard provides greater assurance that individuals will receive appropriate services. The requirement that the Division conduct an extended evaluation before issuing a certificate of ineligibility pursuant to proposed N.J.A.C. 12:45-1.8 will have a similar impact as that of the "clear and convincing" standard.

The amendments to the order of selection found at N.J.A.C. 12:45-1.9 will benefit individuals with the most severe disabilities, should have minimal impact on individuals with severe disabilities and will adversely impact individuals with less severe disabilities because of a lack of resources. Proposed N.J.A.C. 12:45-1.10 will benefit individuals with disabilities, the Department and the public by setting standards for the maintenance of individual case records with which to administer the program. In a similar manner, proposed N.J.A.C. 12:45-1.11, which sets forth the procedures for the individualized written rehabilitation program (IWRP), benefits the clients served, the Department and the public.

Proposed N.J.A.C. 12:45-1.12 emphasizes the mutual participation of the vocational rehabilitation client in choosing the direction of his or her personal vocational objective. The increased emphasis on placement in integrated settings, the consideration of rehabilitation technology, personal assistance services, and post-employment services relative to each objective which must be met for an individual to achieve his or her goals creates considerably more work for the Department; however, this increased workload will benefit individuals with disabilities.

N.J.A.C. 12:45-1.13 regarding vocational rehabilitation services, particularly the addition of personal assistance services and transition services will benefit individuals with disabilities as mentioned in the definitions section above.

The readoption of N.J.A.C. 12:45-1.15 regarding the participation by clients in the cost of vocational rehabilitation services benefits those clients with the least resources the most and those clients with the most resources the least. The public and Department benefit from a reasonable distribution of available resources.

Proposed N.J.A.C. 12:45-1.16 regarding the release of personal information protects the privacy rights of individuals with disabilities and protects the Department by providing guidelines for the release of client information to others.

The appeal rights set forth at N.J.A.C. 12:45-1.17 benefits individuals with disabilities by affording them the right to both an administrative review and a fair hearing. There are additional burdens on state government because of a restricted definition of "impartial hearing officer;" however, the State's Office of Administrative Law will be able to meet these responsibilities.

The addition of "personal auto" at N.J.A.C. 12:45-2.1 and 2.2 benefits individuals with disabilities who use this mode of transport to their extended employment site by recognizing such transportation expenses as reimbursable. There is no impact on the public or Department.

N.J.A.C. 12:45-2.3 and Appendix A have no impact on individuals with disabilities or the public. The Department and community rehabilitation programs benefit from a simplified reporting format and more reasonable time frames for reporting.

The ammendments at N.J.A.C. 12:45-2.4 and 2.5 concerning methods of payment and disbursement of funds benefit individuals with disabilities and the Department by simplifying calculations and providing an equitable distribution of funds based on actual allowable costs rather than projected need. There is no impact on the public.

Economic Impact

The vocational rehabilitation program facilitates the employment of individuals with disabilities. Their status as wage earners is beneficial by providing a measure of economic self-sufficiency. The public and the Department also benefit in the form of tax contributions and other revenues which support the economy. Achievement of employment goals is also expected to lessen economic dependence on the State. Society benefits from their increased productivity, self-sufficiency and economic independence. Accordingly, the overall economic impact of the proposed rules is expected to be positive for individuals with disabilities, the public and the Department, despite the possibility of some negative economic impact to certain groups of individuals occasioned by the changes required by the 1992 Federal amendments.

Specifically, the presumption that individuals with the most severe disabilities can benefit from vocational rehabilitation services which permeates these rules will economically benefit individuals with the most severe disabilities who may otherwise have been denied vocational rehabilitation services or have been provided a more narrow array of services. Individuals with the most severe disabilities and individuals with severe disabilities as defined in the proposed rules will realize the greatest benefit, while individuals with less severe disabilities will benefit less directly if there are insufficient resources. To the extent that fewer individuals are served, the general public is affected by the loss of revenues to the State generated through the employment of individuals with disabilities. In addition, the State may be required to allocate additional resources from its general revenues to service individuals with disabilities who could not otherwise be served by the Division. Changes in the order of selection at N.J.A.C. 12:45-1.9 and the addition of personal assistance services as an additional vocational rehabilitation service will have a similar impact.

In light of the recent Federal amendments, the Department has no experiential data with which to project the costs associated with clients' choices in terms of alternative goals, objectives, services, entities providing service and methods used to procure services. While efforts will be made to contain costs, increased costs per person served may result. However, to the extent individuals with disabilities achieve their vocational rehabilitation goals, these individuals will generate revenues which will benefit the State.

The emphasis by the rules on employment outcomes and more placement in integrated settings should be of economic benefit to individuals with disabilities, the Department and the public because wages paid at integrated settings are generally higher than those at segregated settings. Rehabilitation facilities maintaining segregated programs may experience a negative financial impact since it is expected that there will be a decrease in the number of referrals to these facilities.

The data and information obtained from clients through the application and referral, preliminary assessment, and comprehensive assessment processes under N.J.A.C. 12:45-1.3, 1.5 and 1.6 respectively, and implied in the deletion of the evaluation requirement of N.J.A.C. 12:45-1.14 should provide an economic benefit to clients, the public and the Department by making resources that would otherwise have been used for evaluations available for additional services.

The application of the "clear and convincing" standard (N.J.A.C. 12:45-1.7), the requirement that the Division conduct an extended evaluation under certain circumstances (N.J.A.C. 12:45-1.8), the increase in documentation requirements (N.J.A.C. 12:45-1.9) and the amendments to appeal rights (N.J.A.C. 12:45-1.17) require the expenditure of funds to ensure that all potentially eligible individuals with disabilities are provided with a significant opportunity to achieve their vocational rehabilitation objectives. In addition, funds must be allocated for the conduct of fair hearings to ensure an objective review of the program's decisions; however, the provision of administrative reviews will ensure that appeals can be resolved expeditiously and at less costs, where possible. These are necessary costs for the proper administration of the program. To the extent hindsight reveals that individuals are ineligible for services, resources may be diverted from eligible individuals who could have benefitted from services in terms of an employment outcome to documenting ineligibility decisions and providing services to individuals who ultimately do not benefit in terms of an employment outcome.

The proposed rule at N.J.A.C. 12:45-1.13 which limits maintenance payments to "additional costs incurred while participating in rehabilitation" rather than the pre-1992 "estimated cost of subsistence" level will make more resources available for the provision of vocational rehabilitation services to eligible individuals. To the extent individuals received the funds under the previous rule, these individuals will be adversely affected; however, the economic impact is likely not to be significant because of the very modest level of support being given.

The proposed readoption of N.J.A.C. 12:45-1.15 regarding the participation by clients in the cost of vocational rehabilitation services allocates resources based upon economic need. As a result, those clients with the least resources are provided greater financial support while those clients with greater resources are assisted to a lesser extent. The public and Department benefit from an equitable distribution of available resources so that the greatest number of individuals reach their vocational rehabilitation goals.

The amendments at N.J.A.C. 12:45-2 benefit all eligible individuals by providing a formula which reimburses clients based on the percent of all total travel expenses that can be covered in a given fiscal year. The percentage is applied to each client, thereby equally distributing the available funds. Clients are adversely affected if the funds are insufficient to cover 100 percent of their expenses.

Regulatory Flexibility Analysis

The rules proposed for readoption with amendments govern the administration and implementation of vocational rehabilitation services provided by the Division. No requirements are imposed on small businesses, as that term is defined under the Regulatory Flexibility Act, N.J.S.A. 52:14B-16 et seq., with the possible exception of the requirement imposed on community rehabilitation programs by amended N.J.A.C. 12:45-2.3 to submit to the Division biannual surveys of client transportation needs. Preparation and submission of the surveys will not cause significant costs to be incurred, and no professional services need be employed. As the information provided is necessary for the Division to establish categories of expenses as a basis for transportation reimbursement, no lesser requirement or exemption can be provided.

Full text of the proposed readoption may be found in the New Jersey Administrative Code at N.J.A.C. 12:45.

Full text of the proposed repeal may be found in the New Jersey Administrative Code at N.J.A.C. 12:45-3.

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

SUBCHAPTER 1. PROCEDURES AND STANDARDS

12:45-1.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the procedures, standards and criteria used by the Division of Vocational Rehabilitation Services to rehabilitate individuals with [handicaps] **disabilities.**

(b) (No change.)

12:45-1.2 Definitions

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

"Act" means the Rehabilitation Act, 29 U.S.C. §§701 et seq., **as amended by the Rehabilitation Act Amendments of 1992, P.L. 102-569.**

["Competitive work," as used in the definition of "supported employment," means work that is performed on a full-time basis or on a part-time basis, averaging at least 20 hours per week for each pay period, and for which an individual is compensated in accordance with the Fair Labor Standards Act, 29 U.S.C. §§201 et seq.]

"Assessment for determining eligibility and vocational rehabilitation needs" means, as appropriate in each case:

1. A review of existing data:

i. To determine whether an individual is eligible for vocational rehabilitation services; and

ii. To assign the priority described in the order of selection found at N.J.A.C. 12:45-1.9;

2. To the extent additional data is necessary to make the determination and assignment in 1 above, a preliminary assessment of such data (including the provision of goods and services during such assessment);

3. To the extent additional data is necessary, a comprehensive assessment (including the administration of the assessment) of the

unique strengths, resources, priorities, interests and needs, including the need for supported employment, of an eligible individual to make a determination of the goals, objectives, nature and scope of vocational rehabilitation services to be included in the individualized written rehabilitation program of the individual, which comprehensive assessment:

i. Is limited to the information that is necessary to identify the rehabilitation needs of the individual and to develop the rehabilitation program of the individual;

ii. Uses, as a primary source of such information, to the maximum extent possible and appropriate and in accordance with confidentiality requirements;

(1) Existing information; and

(2) Such information as can be provided by the individual and, where appropriate, by the family of the individual.

iii. May include, to the degree needed to make such a determination, an assessment of the personality, interests, interpersonal skills, intelligence and related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments, and employment opportunities of the individual, and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational and environmental factors, that affect the employment and rehabilitation needs of the individual; and

iv. May include an appraisal of the patterns of work behavior of the individual and services needed for the individual to acquire occupational skills and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance, including the utilization of work in real job situations to assess and develop the capacities of the individual to perform adequately in a work environment; and

4. Referral;

i. Where appropriate, the provision of rehabilitation technology services to an individual with a disability to assess and develop the capacities of the individual to perform in a work environment;

ii. The provision of vocational rehabilitation services to an individual for a total period not in excess of 18 months for the limited purpose of making determinations regarding whether an individual is eligible for vocational rehabilitation services and regarding the nature and scope of vocational rehabilitation services needed for such individual; and

iii. An assessment at least once in every 90-day period during which such services are provided, of the results of the provision of such services to an individual to ascertain whether any of the determinations described in subparagraph 4ii above may be made.

"Clear and convincing evidence" means that proof which results in reasonable certainty of the truth of the ultimate fact in controversy. Clear and convincing proof will be shown where the truth of the facts asserted is highly probable.

"Community rehabilitation program" means a program that provides directly, or facilitates the provision of, vocational rehabilitation services to individuals with disabilities and that provides, singly or in combination, for an individual with a disability to enable the individual to maximize opportunities for employment, including career advancement:

1. Medical, psychiatric, psychological, social and vocational services that are provided under one management;

2. Testing, fitting, or training in the use of prosthetic and orthotic devices;

3. Recreational therapy;

4. Physical and occupational therapy;

5. Speech, language and hearing therapy;

6. Psychiatric, psychological and social services, including positive behavior management;

7. Assessment for determining eligibility and vocational rehabilitation needs;

8. Orientation and mobility services for individuals who are blind;

9. Extended employment;

10. Psychosocial rehabilitation services;

11. Supported employment services and extended services;

12. Services to family members when necessary to the vocational rehabilitation of the individual;

13. Personal assistive services; or

14. Services similar to the services described in paragraphs 1 through 13 above.

"Disability" means a physical or mental impairment that constitutes or results in a substantial impediment to employment.

["Disabled public safety officer" means a non-severely disabled individual whose handicapping condition arose from a disability sustained in the line of duty while performing as a public safety officer and the immediate cause of such disability was a criminal act, apparent criminal act, or a hazardous condition resulting directly from the officer's performance of duties in direct connection with the enforcement, execution, and administration of law or fire prevention, firefighting, or related public safety activities.]

"Division" means the Division of Vocational Rehabilitation Services (DVRS), New Jersey Department of Labor.

["Eligible" or "eligibility," when used in relation to an individual's qualification for vocational rehabilitation services, refers to a certification that:

1. An individual has a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment; and

2. Vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability.

"Employability" means a determination that, with the provision of vocational rehabilitation services, the individual is likely to enter or retain, as a primary objective, full-time employment, or, if appropriate, part-time employment, consistent with the capacities or abilities of the individual in the competitive labor market; the practice of a profession; self-employment; homemaking; farm or family work (including work for which payment is in kind rather than in cash); sheltered employment; home-based employment; supported employment; or other gainful work.]

"Employment outcome" means, with respect to an individual, entering or retaining full-time or, if appropriate, part-time competitive employment in the integrated labor market (including satisfying the vocational outcome of supported employment) or satisfying any other vocational outcome the Secretary of the U.S. Department of Education may determine consistent with the Act.

["Evaluation of vocational rehabilitation potential" means, as approriate, in each case:

1. A preliminary diagnostic study to determine that the individual has a substantial handicap to employment, and that vocational rehabilitation services are needed;

2. A diagnostic study consisting of a comprehensive evaluation of pertinent medical, psychiatric, psychological, vocational, educational, cultural, social, recreational, and environmental factors which bear on the individual's handicap to employment and rehabilitation potential including, to the degree needed, an evaluation of the individual's employability, personality, intelligence level, educational achievements, work experience, vocational aptitudes and interests, personal and social adjustments, employment opportunities, and other pertinent data helpful in determining the nature and scope of services needed;

3. An appraisal of the individual's patterns of work behavior and ability to acquire occupational skill, and to develop work attitudes, work habits, work tolerance, and social behavior patterns suitable for successful job performance, including the utilization of work simulated or real, to assess and develop the individual's capacities to perform adequately in a work environment;

4. Any other goods or services provided for the purposes of ascertaining the nature of the handicap and whether it may reasonably be expected that the individual can benefit from vocational rehabilitation services;

5. Referral;

6. The administration of these evaluation services;

7. The provision of vocational rehabilitation services to any individual for a total period not in excess of eighteen months for the purpose of determining whether such individual is an individual with handicaps, an individual with handicaps for whom a vocational goal is not possible or feasible, or neither such individual; and an assessment, at least once in every ninety-day period during which

such services are provided, of the results of the provision of such services to an individual to ascertain whether any of the determinations described in the preceding clause of this paragraph may be made; and

8. Where appropriate, the provision of rehabilitation engineering services to any individual with a handicap to assess and develop the individual's capacities to perform adequately in a work environment (see 29 U.S.C. sec. 706(5)).]

"Extended services" means ongoing support services and other appropriate services, needed to support and maintain an individual with the most severe disability in supported employment, that:

1. Are provided singly or in combination and are organized and made available in such a way as to assist an eligible individual in maintaining integrated, competitive employment;

2. Are based on a determination of the needs of an eligible indivdual, as specified in an individualized written rehabilitation program; and

3. Are provided by a State agency, a nonprofit private organization, employer, or any other appropriate resource, after an individual has made the transition from services provided by the Division.

["Extreme medical risk" means a risk of substantially increasing functional impairment or risk of death if medical services are not provided expeditiously.]

"Family member" or "member of the family" means any relative by blood or marriage of an individual with [handicaps] **a disability** and any other individual living in the same household with whom the individual with [handicaps] **a disability** has a close interpersonal relationship:

["Impartial hearing officer" means an individual:

1. Who is not an employee of a public agency that is involved in any decision regarding the furnishing or denial of rehabilitation services to a vocational rehabilitation applicant or client. An individual is not an employee of a public agency solely because the individual is paid by the agency to serve as a hearing officer;

2. Who has not been involved in previous decisions regarding the vocational rehabilitation applicant or client;

3. Who has background and experience in, and knowledge of, the delivery of vocational rehabilitation services; and

4. Who has no personal or financial interest that would be in conflict with the individual's objectivity.]

"Impartial hearing officer" means:

1. An individual who:

i. Is not an employee of a public agency (other than an administrative law judge, hearing examiner, or employee of an institution of higher education);

ii. Is not a member of the State Rehabilitation Advisory Council created by the Governor by Executive Order;

iii. Has not been involved in previous decisions regarding the vocational rehabilitation of the applicant or client;

iv. Has knowledge of the delivery of vocational rehabilitation services, the State Plan and the Federal and State rules governing the provision of such services and training with respect to the performance of official duties; and

v. Has no personal or financial interest that would be in conflict with the objectivity of the individual.

2. An individual shall not be considered to be an employee of a public agency for purposes of subparagraph 1i above solely because the individual is paid by the agency to serve as a hearing officer.

["Individual with handicaps" means an individual:

1. Who has a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment; and

2. Who can reasonably be expected to benefit in terms of employability from the provision of vocational rehabilitation services, or for whom an extended evaluation of vocational rehabilitation potential is necessary to determine whether the individual might reasonably be expected to benefit in terms of employability from the provision of vocational rehabilitation services.

"Individual with severe handicaps" means an individual:

1. Who has a severe physical or mental disability which seriously limits one or more functional capacities (mobility, communication, self-care, self-direction, work tolerance, or work skills) in terms of employability;

2. Whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time; and

3. Who has one or more physical or mental disabilities resulting from amputation, arthritis, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, hemophilia, respiratory or pulmonary dysfunction, mental retardation, mental illness, multiple sclerosis, muscular dystrophy, musculo-skeletal disorders, neurological disorders (including stroke and epilepsy), paraplegia, quadriplegia, and other spinal cord conditions, sickle cell anemia, specific learning disability, and end-stage renal disease, or another disability or combination of disabilities determined on the basis of an evaluation of rehabilitation potential to cause comparable substantial functional limitation.]

"Individual with a disability" means any individual who:

1. Has a physical or mental impairment which for such individual constitutes or results in a substantial impediment to employment; and

2. Can benefit in terms of an employment outcome from vocational rehabilitation services.

"Individual with a severe disability" means an individual with a disability:

1. Who has a severe physical or mental impairment or combination of impairments which seriously limits one functional capacity (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance or work skills) in terms of an employment outcome; and

2. Whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time.

"Individual with a most severe disability" means an individual with a disability:

1. Who has a severe physical or mental impairment or combination of impairments which seriously limits two or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome; and

2. Whose vocational rehabilitation can be expected to require multiple vocational rehabilitation services over an extended period of time.

"Integrated work setting," as used in the definition of "supported employment," means job sites where:

1. Most co-workers are not [handicapped] **individuals with disabilities**[,] and individuals with [handicaps] **disabilities** are not part of a work group of other individuals with [handicaps] **disabilities**; or

2. Most co-workers are not [handicapped] **individuals with disabilities**, and if a job site described in paragraph 1 above is not possible, individuals with [handicaps] **disabilities** are part of a small work group of not more than eight individuals with [handicaps] **disabilities**; or

3. If there are no co-workers or the only co-workers are members of a small work group of not more than eight individuals, all of whom have [handicaps] **disabilities**, individuals with [handicaps] **disabilities** have regular contact with [non-handicapped] individuals **who do not have disabilities**, other than personnel providing support services, in the immediate work setting.

"Ongoing support services" means services:

1. Provided to the individuals with the most severe disabilities;

2. Provided, at a minimum, twice monthly:

i. To make an assessment, regarding the employment situation, at the worksite of each such individual in supported employment, or under special circumstances, especially at the request of the client, off-site; and

ii. Based on the assessment, to provide for the coordination or provision of specific intensive services, at or away from the worksite, that are needed to maintain employment stability; and

3. Consisting of:

i. A particularized assessment supplementary to the comprehensive assessment;

ii. The provision of skilled job trainer(s) who may accompany the individual for intensive job skill training at the worksite;

iii. Job development and placement;

iv. Social skills training;

v. Regular observation or supervision of the individual;

vi. Follow-up services such as regular contact with the employers, the individuals, the parents, family members, guardians, and other suitable professional and informed advisors, in order to reinforce and stabilize the job placement;

vii. Facilitation of natural supports at the worksite;

viii. Any other vocational rehabilitation service; or

ix. A service similar to another service described in this paragraph.

"Personal assistance services" means a range of services, provided by one or more persons, designed to assist an individual with a

disability to perform daily living activities on or off the job that the individual would typically perform if the individual did not have a disability. Such services shall be designed to increase the individual's control in life and ability to perform everyday activities on or off the job.

["Physical and mental restoration services" means:

1. Medical or corrective surgical treatment;
2. Diagnosis and treatment for mental or emotional disorders by a physician skilled in the diagnosis and treatment of such disorders or by a psychologist licensed or certified in accordance with State laws and regulations;
3. Dentistry;
4. Nursing services;
5. Necessary hospitalization (either inpatient or outpatient care) in connection with surgery or treatment and clinic services;
6. Convalescent or nursing home care;
7. Drugs and supplies;
8. Prosthetic, orthotic or other assistive devices including hearing aids, essential to obtaining or retaining employment;
9. Eyeglasses and visual services, including visual training, and the examination and services necessary for the prescription and provision of eyeglasses, contact lenses, microscopic lenses, telescopic lenses, and other special visual aids, prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select. (All cases involving blind and visually impaired individuals with a level of visual functioning directly impacting on the handicap to employment shall be referred to the New Jersey Commission for the Blind and Visually Impaired for services.);
10. Podiatry;
11. Physical therapy;
12. Occupational therapy;
13. Speech or hearing therapy;
14. Psychological services;
15. Therapeutic recreation services;
16. Medical or medically related social work services;
17. Treatment of either acute or chronic medical complications and emergencies which are associated with or arise out of the provision of physical and mental restoration services; or which are inherent in the condition under treatment;
18. Special services for the treatment of individual suffering from end-stage renal disease, including transplantation, dialysis, artificial kidneys, and supplies; and
19. Other medical or medically related rehabilitation services that would contribute to the reduction or elimination of barriers to employment including art therapy, dance therapy, music therapy and psychodrama.

"Physical or mental disability" means a physical or mental condition which materially limits, contributes to limiting or, if not corrected, will probably result in limiting an individual's employment activities or vocational functioning.]

"Public safety officer" means a person serving the United States or a State or unit of general local government, with or without compensation, in any activity pertaining to:

1. The enforcement of the criminal laws, including highway patrol, or the maintenance of civil peace by the National Guard or the Armed Forces;

2. A correctional program, facility, or institution where the activity is potentially dangerous because of contact with criminal suspects, defendants, prisoners, probationers, or parolees;

3. A court having criminal or juvenile delinquent jurisdiction where the activity is potentially dangerous because of contact with criminal suspects, defendants, prisoners, probationers, or parolees; or

4. Firefighting, fire prevention, or emergency rescue missions.

"Rehabilitation [engineering] technology" means the systematic application of technologies, engineering methodologies, or scientific principles to meet the needs of and address the barriers confronted by individuals with [handicaps] **disabilities** in areas [that] **which** include education, rehabilitation, employment, transportation, independent living, and recreation. The term includes rehabilitation engineering, assistive technology devices, and assistive technology services.

["Substantial handicap to employment" means that a physical or mental disability (in light of attendant medical, psychological, vocational, educational, and other related factors) impedes an individual's occupational performance, by preventing the obtaining, retaining, or preparing for employment consistent with the individual's capacities and abilities.

"Supported employment" means:

1. Competitive work in an integrated work setting with ongoing support services for individuals with severe handicaps for whom competitive employment:
   i. Has not traditionally occurred; or
   ii. Has been interrupted or intermittent as a result of severe handicaps; or
2. Transitional employment for individuals with chronic mental illness.]

"Supported employment" means competitive work in integrated work settings for individuals with the most severe disabilities:

1. For whom competitive employment has not traditionally occurred, or for whom competitive employment has been interrupted or intermittent as a result of a severe disability; and

2. Who, because of the nature and severity of their disability, need intensive supported employment services or extended services in order to perform such work. Such term includes transitional employment for persons who are individuals with the most severe disabilities due to mental illness.

"Supported employment services" means ongoing support services and other appropriate services needed to support and maintain an individual with the most severe disability in supported employment, that:

1. Are provided singly or in combination and are organized and made available in such a way to assist an eligible individual in entering or maintaining integrated competitive employment;

2. Are based on a determination of the needs of an eligible individual, as specified in an individualized written rehabilitation program; and

3. Are provided by the Division for a period of time not to extend beyond 18 months, unless under special circumstances the eligible individual and the rehabilitation counselor or coordinator jointly agree to extend the time in order to achieve the rehabilitation objectives identified in the individualized written rehabilitation program.

i. Special circumstances that would warrant consideration of an extension of services beyond 18 months may include an interruption of service during the 18 month period, significant changes in either job functions or supervision during the 18 month period or any other special circumstances providing there is reason to believe that an extension would allow the eligible individual to achieve the rehabilitation objectives identified in the individualized written rehabilitation program.

"Transition services" means a coordinated set of activities for a student designed within an outcome-oriented process, that promotes movement from school to post-school activities, including post-secondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation. The coordinated set of activities shall be based upon the individual student's needs, taking into account the student's preferences and interests, and shall include instruction, community experiences, the development of employment and other post-school adult living objectives, and when appropriate, acquisition of daily living skills and functional vocational evaluation.

["Vocational rehabilitation services" means services that are dedicated to the reduction or elimination of the barriers to employability.

1. When provided to an individual, also means those services listed in N.J.A.C. 12:45-1.13.
2. When provided for the benefit of groups of individuals, also means:
   i. The establishment of a rehabilitation facility;
   ii. The construction of a rehabilitation facility;

iii. The provision of other facilities and services, including services provided at rehabilitation facilities, which promise to contribute substantially to the rehabilitation of a group of individuals but which are not related directly to the individualized written rehabilitation program of any one individual with handicaps;

iv. The use of existing telecommunications systems; and

v. The use of services providing captioned films or video cassettes for deaf persons.]

12:45-1.3 Processing applications and referrals

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

(e) If the information received from an individual or his or her representative indicates legal blindness (N.J.S.A. 30:6-18(a)), visual impairment (N.J.S.A. 30:6-18(c)) or demonstrates other indications of possible eligibility for services provided by the New Jersey Commission for the Blind and Visually Impaired, as outlined in the Agreement of Cooperation between the Division and the New Jersey Commission for the Blind and Visually Impaired, that individual shall be referred to the [Commission] **New Jersey Commission for the Blind and Visually Impaired** for vocational rehabilitation and other services.

(f) The counselor shall determine eligibility within a reasonable period of time, not to exceed 60 days after the individual has submitted an application to receive services, unless the counselor notifies the individual that exceptional and unforseen circumstances beyond the control of the Division preclude it from completing the determination within the prescribed time, and:

1. The individual agrees that an extension of time is warranted; or

2. An extended evaluation is required.

12:45-1.4 Eligibility for vocational rehabilitation services

(a) An individual shall be eligible for vocational rehabilitation services if the counselor determines that the following exists:

1. A physical or mental [disability] **impairment** which for the individual constitutes or results in a substantial [handicap] **impediment** to employment; and

2. A [reasonable expectation that] **need for** vocational rehabilitation services [may benefit the individual in terms of employability] **to prepare for, enter, engage in, or retain gainful employment.**

(b) Each counselor shall apply the eligibility requirements without regard to sex, race, age, creed, color [or], national origin **or disability** of the individual applying for service.

(c) (No change.)

(d) No upper or lower age limit shall be established which will, in and of itself, result in a finding of ineligibility [for] **of** any individual with [handicaps] **a disability** who otherwise meets the eligibility requirements set forth in (a) above.

(e)-(f) (No change.)

12:45-1.5 [Evaluation of vocational rehabilitation potential: preliminary diagnostic study] **Preliminary assessment**

[(a) In order to determine whether any individual is eligible for vocational rehabilitation services, the counselor shall conduct a preliminary diagnostic study to determine:

1. Whether the individual has a physical or mental disability which for that individual constitutes or results in a substantial handicap to employment; and

2. Whether vocational rehabilitation services may reasonably be expected to benefit the individual in terms of employability, or whether an extended evaluation of vocational rehabilitation potential is necessary to make this determination.]

(a) A preliminary assessment based upon the review of existing data shall be conducted to determine whether an individual is eligible for vocational rehabilitation services and to assign the priority category for the order of selection for services pursuant to N.J.A.C. 12:45-1.9.

[(b) The preliminary diagnostic study shall include:

1. An appraisal of the current general health status of the individual based, to the maximum extent possible, on available medical information;

2. An evaluation by the appropriate medical specialist when necessary to determine the current status of the disorder; and

3. As appropriate, evaluations by qualified personnel of the potential to benefit from rehabilitation engineering services.]

(b) To the extent additional data is necessary to make such determination and assignment, such data will be secured by the counselor.

[(c) In all cases of mental or emotional disorder, an examination shall be provided by a physician skilled in the diagnosis and treatment of such disorders, or by a psychologist licensed in accordance with the laws and rules of the State of New Jersey. In cases of mental retardation, reports from certified school psychologists may be used to document the disability.

(d) If appropriate, an individual may select his or her own physicians to conduct the necessary medical examinations provided the physician will accept Division fees.]

12:45-1.6 [Evaluation of vocational rehabilitation potential: thorough diagnostic study] **Comprehensive assessment**

[(a) Upon determination of eligibility, the counselor shall conduct a thorough diagnosis study to determine the nature and scope of services needed by the individual.]

(a) A comprehensive assessment of the unique strengths, resources, priorities, interest, and needs, including the need for supported employment, of an eligible individual to make a determination of the goals, objectives, nature and scope of vocational rehabilitation services to be included in the Individualized Written Rehabilitation Program of the individual will be conducted. The comprehensive assessment:

1. Is limited to information that is necessary to identify the rehabilitation needs of the individual and to develop the rehabilitation program of the individual;

2. Uses, as the primary source of such information to the maximum extent possible and appropriate and in accordance with confidentiality requirements:

i. Existing information; and

ii. Such information as can be provided by the individual and where appropriate, by the family of the individual;

3. May include, to the degree needed to make such a determination, an assessment of the personality, interest, interpersonal skills, intelligence, related functional capacities, educational achievements, work experience, vocational aptitudes, personal and social adjustments of and employment opportunities for the individual, and the medical, psychiatric, psychological, and other pertinent vocational, educational, cultural, social, recreational, and environmental factors, that affect the employment and rehabilitation needs of the individual;

4. May include an appraisal of the patterns of work behavior of the individual to acquire occupational skills, and to develop work attitudes, work habits, work tolerance, and social and behavior patterns necessary for successful job performance including the utilization of work in real job situations to assess and develop the capacities of the individuals to perform adequately in a work environment; and

5. May provide rehabilitation technology services, where appropriate, to an individual with a disability to assess and develop the capacities of the individual to perform in a work environment.

[(b) The thorough diagnostic study includes in all cases to the degree needed, an appraisal of the individual's:

1. Functional capacities and limitations;
2. Personality;
3. Intelligence level;
4. Educational achievement;
5. Work experience;
6. Personal, vocational and social adjustment;
7. Employment opportunities;
8. Patterns of work behavior;
9. Ability to acquire occupational skill;
10. Capacity for successful job performance;
11. Employability;
12. Need for rehabilitation engineering services; and
13. Other pertinent data.]

12:45-1.7 Extended evaluation [to determine vocational rehabilitation potential]

(a) Eligibility for vocational rehabilitation services under a plan for extended evaluation shall be determined **based** only upon:

1. The presence of a physical or mental disability which for the individual constitutes or results in a substantial [handicap] **impediment** to employment; and

2. An inability to make a determination that vocational rehabilitation services might benefit the individual in terms of [employability unless there is an extended evaluation to determine vocational rehabilitation potential] **achieving an employment outcome due to the severity of the disability.**

(b) The extended evaluation period shall begin on the date of certification for extended evaluation [to determine rehabilitation potential].

1.-2. (No change.)

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

(e) The extended evaluation shall be terminated at any time before the end of the 18-month extended evaluation when:

[1. The individual is found eligible for vocational rehabilitation services since there is a reasonable assurance that he or she can be expected to benefit in terms of employability from vocational rehabilitation services; or

2. The individual is found ineligible for any additional vocational rehabilitation services since it has been determined on the basis of clear evidence that he or she cannot be expected to benefit in terms of employability from vocational rehabilitation services.]

1. It is determined that the individual with a disability can benefit in terms of an employment outcome from vocational rehabilitation services and thus is found eligible for such services; or

2. The individual is found ineligible for additional vocational rehabilitation services because it has been determined, on the basis of clear and convincing evidence, that the individual cannot benefit from vocational rehabilitation services in terms of an employment outcome.

12:45-1.8 Certification: eligibility; extended evaluation [to determine vocational rehabilitation potential]; ineligibility

(a) Before or at the same time that an individual with [handicaps] **a disability** is accepted for vocational rehabilitation services, there shall be a certification **by the counselor** that the individual has met the basic eligibility requirements as set forth [in] **at** N.J.A.C. 12:45-1.4.

1. (No change.)

(b) Before and as a basis for providing an extended evaluation to determine vocational rehabilitation [potential] **eligibility**, there shall be a certification **by the counselor** that the individual has met the requirements [in] **at** N.J.A.C. 12:45-1.7(a).

1. (No change.)

(c) Whenever the counselor determines on the basis of clear **and convincing** evidence that an applicant or recipient of vocational rehabilitation is ineligible for services, the counselor shall sign and date a certification. **In cases where it appears that an ineligibility decision will be reached because of the severity of the disability of an individual not yet determined to be eligible, the counselor shall first conduct an extended evaluation.**

1. (No change.)

i.-iii. (No change.)

(d) (No change.)

(e) The counselor may close a case without any determination of eligibility when an applicant is unavailable during an extended period of time to complete an [evaluation of vocational rehabilitation potential] **assessment** and the counselor has made repeated efforts to contact the individual and to encourage his or her participation.

12:45-1.9 Order of selection for services

(a) (No change.)

(b) After documentation of eligibility and execution of Certification of Eligibility, the following priorities will be followed according to the Director's determination of how many priorities can be served. The order of selection is as follows:

1. Clients classified as [severely handicapped] **individuals with a most severe disability;**

2. [Disabled public safety officers;] **Clients classified as individuals with a severe disability; and**

[3. Non-severely disabled individuals who are also clients of other agencies with whom the Division has written agreements of shared service responsibility; and

4. All other clients.]

3. All other eligible clients.

(c) A public safety officer whose impairment arose from a disability sustained in the line of duty, and the immediate cause of disability being a criminal act, apparent criminal act, or a hazardous condition resulting from the officer's performance of duties in direct connection with the enforcement, execution, and administration, of law or fire prevention, firefighting, or related public safety activities, will receive services on a priority basis within any of the three priority categories to which he or she is assigned.

[(c)](**d**) If the Division cannot serve every individual within the designated priority group due to the amount of available funds, then the Division will provide services to clients in the order in which they applied for services.

Example: If all [severely handicapped] **individuals with a most severe disability** in priority 1 cannot be served due to lack of available funds, then services will be provided to those clients determined to be priority 1, in the order in which they applied for services.

[(d)](**e**) When imposed, the order of selection shall not preclude[;]**:**

[1. Clients whose eligibility was determined prior to the implementation date;]

[2.]**1.** Diagnostics necessary to establish a client's eligibility; **and**

[3. No-cost services;]

[4.]**2.** Post-employment services[; and

5. Programs and services funded under sources other than Title 1 of the Act (Independent Living; Supported Employment; Fairlawn Deaf Program)].

12:45-1.10 Case record for the individual

(a) Each counselor shall maintain for each applicant for, and recipient of, vocational rehabilitation services a case record which shall include, to the extent pertinent, the following information:

1. Documentation concerning the preliminary [diagnostic study] **assessment** supporting the determination of eligibility, the need for an extended evaluation [of vocational rehabilitation potential], and, as appropriate, documentation concerning the [thorough diagnostic study] **comprehensive assessment** supporting the nature and scope of vocational rehabilitation services to be provided;

2. (No change.)

3. Documentation supporting any determination that the individual's [handicaps are] **disability is** severe;

4. Documentation as to periodic assessment of the individual during an extended evaluation [of vocational rehabilitation potential];

5. (No change.)

6. In the event that physical and mental restoration services are provided, documentation supporting the determination that the clinical status of the individual with [handicaps] **a disability** is stable or slowly progressive unless the individual is being provided an extended evaluation [of rehabilitation potential];

7. (No change.)

8. Documentation relating to the participation by the individual with [handicaps] **a disability** in the cost of vocational rehabilitation services if the State unit elects to condition the provision of services on the financial need of the individual;

9. (No change.)

10. Documentation that the individual has been advised of the confidentiality of all information pertaining to his or her case, and documentation and other material concerning any information released about the individual with [handicaps] **a disability** with his or her written consent;

11. Documentation as to the reason for closing the case including the individual's employment status and, if determined to be rehabilitated, the basis on which the employment was determined to be suitable;

i. [The] **Documentation of any reviews in the** case of an individual who has been provided vocational rehabilitation services under an individualized written program but who has been determined after the initiation of these services to be no longer capable of achieving a vocational goal [, documentation of any reviews of this determination shall be included in the record];

12.-13. (No change.)

12:45-1.11 Individualized written rehabilitation program: procedures

(a) When a counselor determines that an individual is eligible for vocational rehabilitation services or that a period of extended evaluation is necessary to determine [rehabilitation potential] **eligibility**, an individualized written rehabilitation program shall be prepared for the individual.

(b)-(e) (No change.)

(f) The counselor shall review the individualized written rehabilitation program as often as necessary but at least on an annual basis.

1. Each individual with [handicaps] **a disability** or, as appropriate, that individual's parent, guardian, or other representative, shall be given an opportunity to review the program and, if necessary, jointly redevelop, and agree to its terms.

12:45-1.12 Contents of the individualized written rehabilitation program **(IWRP)**

[(a) The written rehabilitation program shall be based on a determination of employability designed to achieve the vocational goal of the individual and shall be developed through assessments of the individual's particular rehabilitation needs. Each individualized written rehabilitation program shall, as appropriate, include, but not be limited to, statements concerning;

1. The basis on which a determination has been made, or the basis on which a determination has been made that an extended evaluation of vocational rehabilitation potential is necessary to make a determination of eligibility;

2. The long-range and intermediate rehabilitation objectives established for the individual based on an assessment determined through an evaluation of rehabilitation potential;

3. The specific rehabilitation services to be provided to achieve the established rehabilitation objectives including, if appropriate, rehabilitation engineering services;

4. An assessment of the expected need for post-employment services;

5. The projected dates for the initiation of each vocational rehabilitation service, and the anticipated duration of each service;

6. A procedure and schedule for periodic review and evaluation of progress toward achieving rehabilitation objectives based upon objective criteria, and a record of these reviews and evaluations;

7. A reassessment, prior to case closure, of the need for post-employment services;

8. The views of the individual with handicaps, or, as appropriate, that individual and a parent, guardian, or other representative, including other suitable professional and informed advisors, concerning the individual's goals and objectives and the vocational rehabilitation services being provided;]

(a) The individualized written rehabilitation program (IWRP) must contain the consumer's name and social security number, along with a statement that he or she has been found eligible for extended evaluation services, vocational rehabilitation services, or that the IWRP is an amendment to an earlier plan. Each IWRP shall include statements concerning:

1. The employment objective of the eligible individual, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of the individual;

2. A rationale for the employment objective which is based on the assessment used to determine eligibility and vocational rehabilitation needs, including an assessment of career interests, for the individual, which goals shall, to the maximum extent appropriate, include placement in integrated settings;

3. The intermediate rehabilitation objectives related to the attainment of the consumer's goals, determined through assessment carried out in the most individualized and integrated setting (consistent with the informed choice of the individual);

4. The specific vocational rehabilitation services to be provided, and the projected dates for the initiation of and the anticipated duration of each service;

5. If appropriate, the specific rehabilitation technology services to be provided to assist in the implementation of the individual's intermediate rehabilitation objectives and long-term rehabilitation goals;

6. If appropriate, the specific on-the-job and related personal assistance services to be provided to the client, and, if appropriate and desired by the individual, the training in managing, supervising, and directing personal assistance services to be provided;

7. An assessment of the expected need for post-employment services and, if appropriate, an assessment of the need for extended services;

8. At the time of successful closure, the IWRP must reassess the need for post-employment services and, if appropriate, the need for extended services, including a statement detailing how such services shall be provided or arranged through cooperative agreements with other service providers;

9. The objective criteria, the evaluation procedure, and the review schedule to be used in determining whether the stated goals and objectives are being achieved;

10. The terms and conditions under which the goods and services described in the IWRP will be provided to the individual in the most integrated setting and the identity of the entity or entities that will provide the vocational rehabilitation services and the process used to provide or procure such services;

11. The consideration given to the availability of comparable benefits (similar benefits) to the client or to members of the client's family under any program to meet, in whole or in part, the cost of any vocational rehabilitation services;

12. A description by the individual, in the words of the individual (or, if appropriate, in the words of a parent, a family member, a guardian, an advocate or an authorized representative of the individual) regarding how the individual was informed about and involved in choosing among alternative goals, objectives, services, entities providing such services and the methods used to provide or procure such services;

[9.]**13.** The [terms and conditions for the provisions of vocational rehabilitation services, including] responsibilities of the individual [with handicaps] in implementing the individualized written rehabilitation program[,] **and** the extent of client participation in the cost of services, if any[, and the extent to which comparable services and benefits are available to the individual under any other program];

[10.]**14.** An assurance that the individual [with handicaps] has been informed of that individual's rights and the means by which the individual may express and seek remedy for any dissatisfaction, including the opportunity for a review **and fair hearing** of rehabilitation counselor or coordinator determinations;

[11.]**15.** An assurance that the individual [with handicaps] has been provided a description of the availability of a client assistance program established under section 112 of the Act;

[12.]**16.** The basis on which the individual has been determined to be rehabilitated; and

[13. The plans for the provision of post-employment services after a suitable employment goal has been achieved and the basis on which those plans are developed, and, if appropriate for individuals with severe handicaps, a statement of how these services will be provided or arranged through cooperative agreements with other service providers.]

17. If necessary, an amendment specifying the reasons that an individual for whom a program has been prpared is no longer eligible for vocational rehabilitation and the rights and remedies available to such an individual.

(b) Each individualized written rehabilitation program shall also contain, for individuals with **the most** severe [handicaps] **disabilities** for whom a vocational objective of supported employment has been determined to be appropriate:

1. A description of the time-limited services[, not to exceed 18 months in duration,] to be provided by the State; and

2. A description of the extended services needed[,] **and** an identification of the [State, Federal, or private programs that will provide the continuing support, and a description of the basis for determining that continuing support is available] **source of extended services, which may include natural supports, or to the extent that it is not possible to identify the source of extended services at the time the individualized written rehabilitation program is developed, a statement describing the basis for concluding that there is a reasonable expectation that such sources will become available.**

12:45-1.13 Vocational rehabilitation services

[(a) The following vocational rehabilitation services shall be available:

1. Evaluation of vocational rehabilitation potential, including diagnostic and related services incidental to the determination of eligibility for, and the nature and scope of services to be provided;

2. Counseling and guidance, including personal adjustment counseling, to maintain a counseling relationship throughout the program of services for an individual with handicaps, referral necessary to help individuals with handicaps secure needed services from other agencies, and advising clients and client applicants about client assistance programs under 34 CFR Part 370.

3. Physical and mental restoration services, necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive;

4. Vocational and other training services, including personal and vocational adjustment, books, tools, and other training materials except that no training or training services in institutions of higher education (universities, colleges, community/junior colleges, vocational schools, technical institutes, or hospital schools of nursing) may be paid for with funds under this paragraph unless maximum efforts have been made by the counselor to secure grant assistance in whole or in part from other sources;

5. Maintenance, including payments, not exceeding the estimated cost of subsistence and provided at any time after vocational rehabilitation services have begun through the time when post-employment services are being provided. For an individual with handicaps, maintenance covers basic living expenses, such as food, shelter, clothing, and other subsistence expenses which are necessary to support and derive the full benefit of the other vocational rehabilitation services being provided;

6. Transportation, including necessary travel and related expenses including subsistence during travel (or per diem payments in lieu of subsistence) in connection with transporting individuals with handicaps and their attendants or escorts for the purpose of supporting and deriving the full benefit of the other vocational rehabilitation services being provided. Transportation may include relocation and moving expenses necessary for achieving a vocational rehabilitation objective;

7. Services to members of a client's family when necessary to the vocational rehabilitation of the handicapped individual;

8. Interpreter services and notetaking services for the deaf;

9. Telecommunications, sensory and other technological aids and devices;

10. Recruitment and training services to provide new employment opportunities in the fields of rehabilitation, health, welfare, public safety, law enforcement, other appropriate public service employment, and occupations which are designated as indicative of having significant career growth and employment potential;

11. Placement in suitable employment;

12. Post-employment services necessary to maintain or regain other suitable employment;

13. Occupational licenses, including any license, permit or other written authority required by a State, city or other governmental unit to be obtained in order to enter an occupation or enter a small business, tools, equipment, initial stocks (including livestock) and supplies;

14. Rehabilitation engineering services; and]

(a) Vocational rehabilitation services are any goods or services necessary to render an individual with a disability employable, including, but not limited to, the following:

1. An assessment for determining eligibility and vocational rehabilitation needs by qualified personnel, including, if appropriate, an assessment by personnel skilled in rehabilitation technology;

2. Counseling, guidance, and work-related placement services for individuals with disabilities, including job search assistance, placement assistance, job retention services, personal assistance services, and follow-up, follow-along, and specific postemployment services necessary to assist such individuals to maintain, regain, or advance in employment;

3. Vocational and other training services for individuals with disabilities, which shall include personal and vocational adjustment, books, or other training materials, and such services to the families of such individuals as are necessary to the adjustment or rehabilitation of such individuals, except that no training services in institutions of higher education shall be paid for unless maximum efforts have been made to secure grant assistance, in whole or in part, from other sources to pay for such training;

4. Physical and mental restoration services, including but not limited to:

i. Corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical or mental condition which is stable or slowly progressive and constitutes an impediment to employment, but is of such nature that such correction or modification may reasonably be expected to eliminate or reduce such impediment to employment within a reasonable length of time;

ii. Necessary hospitalization in connection with surgery or treatment;

iii. Prosthetic and orthotic devices; and

iv. Diagnosis and treatment for mental and emotional disorders by a physician or licensed psychologist in accordance with State licensure laws;

5. Maintenance for additional costs incurred while participating in rehabilitation;

6. Interpreter services for individuals who are deaf;

7. Occupational licenses, tools, equipment, and initial stocks and supplies;

8. Transportation in connection with the rendering of any vocational rehabilitation service;

9. Telecommunications, sensory, and other technological aids and devices;

10. Rehabilitation technology services;

11. Referral and other services designed to assist individuals with disabilities in securing needed services from other agencies;

12. Transition services that promote or facilitate the accomplishment of long-term rehabilitation goals and intermediate rehabilitation objectives;

13. On-the-job or other related personal assistance services provided while an individual with a disability is receiving vocational rehabilitation services in this section;

14. Supported employment services; and

15. Other goods and services that can reasonably be expected to benefit an individual with [handicaps] **a disability** in terms of [employability] **an employment outcome.**

(b) Vocational rehabilitation services, when provided for the benefit of groups of individuals, may also include the following:

1. The establishment, development or improvement of community rehabilitation programs, including, under special circumstances as described at 34 CFR 361.74, the construction of a facility, and the provision of other services (including services offered at community rehabilitation programs) which promise to contribute substantially to the rehabilitation of a group of individuals but which are not related directly to the individualized rehabilitation written program of any one individual with a disability. Such programs shall be used to provide services that promote integration and competitive employment.

2. Technical assistance and support services to businesses that are not subject to title I of the Americans with Disabilities Act of

1990 (42 U.S.C. 12111 et seq.) and that are seeking to employ individuals with disabilities.

12:45-1.14 Individuals determined to be rehabilitated

(a) In order to be determined rehabilitated, an individual must have been, as a minimum:

1. (No change.)

2. Provided [an evaluation of vocational rehabilitation potential, and] counseling and guidance as essential vocational rehabilitation services;

3.-4. (No change.)

(b) (No change.)

12:45-1.15 (No change.)

12:45-1.16 Protection; use and release of personal information

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

(e) The requirements for release of information for audit, evaluation, and research [is] **are** as follows:

1. Personal information may be released to an organization, agency or individual engaged in audit, evaluation, or research only for purposes directly connected with the administration of the vocational rehabilitation program, or for purposes which would significantly improve the quality of life for [handicapped persons] **individuals with disabilities**, and only if the organization, agency, or individual assures that:

i.-v. (No change.)

(f) The requirements for release of information to other programs or authorities is as follows:

1. (No change.)

2. The Division shall release personal information if required by Federal **or State** law;

3. The Division shall release personal information in response to investigations in connection with law enforcement, fraud, or abuse, (except where expressly prohibited by Federal or State laws or regulations), and in response to judicial order; [and]

4. The Division may also release personal information **in a medical emergency or** in order to protect the individual or others when the individual poses a threat to his or her safety or to the safety of others[.];

5. The Division shall release personal information when requested by and given to the individual as provided at (d) above; and

6. This Division shall release personal information without a signed release statement when such information is necessary to provide the authorized services only to:

i. Doctors, hospitals, clinics, rehabilitation centers providing services to clients as authorized by the Division; and

ii. Schools or training centers, when the Division has authorized service, and such information is required for the success of the program, safety of the client, or is otherwise in the client's best interest.

12:45-1.17 Appeal of vocational rehabilitation **decision by** applicant or recipient

(a) All applicants/clients for vocational rehabilitation shall be advised of their right to [a] **an administrative** review **and/or a fair hearing** in the event that they are dissatisfied with any determination with regard to the furnishing or denial of vocational rehabilitation services.

1. [A] **An administrative** review **and/or a fair hearing** must be requested in writing by the applicant or client. This written request should be submitted to the Director, Division of Vocational Rehabilitation Services.

2. The review **or hearing** shall be held at a time and place convenient for the applicant or client.

3. The applicant or client will be notified of the date, time and place of the review **or hearing**. The notification will be sent in advance of the review **or hearing** and provide enough time for the applicant or client to prepare for the review **or hearing**.

4. The applicant or client may be represented by counsel, friend, Client Assistance Program located in the Department of the Public Advocate, parent, guardian, self, or other representative. All correspondence, decisions, scheduling of **an administrative review or** fair hearing, or other documents sent to the client, which are related to the appeal will be copied and sent to the representative.

5. The applicant or client and his or her representative, if he or she desires to have one, will be given an adequate opportunity for cross examination and to present evidence and/or witnesses on his or her behalf during the review **or fair hearing**.

6. The review shall be held before [an impartial hearing officer] **a Division administrator** within [45] **14** days of the request by the applicant or client for a review. **Fair hearings shall be conducted by an impartial hearing officer who shall be an administrative law judge within 45 days of the request by the applicant or client for a fair hearing 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, and Federal regulation.**

7.-11. (No change.)

SUBCHAPTER 2. TRANSPORTATION FOR EMPLOYEES [OF SHELTERED WORKSHOPS] **CERTIFIED FOR EXTENDED EMPLOYMENT**

12:45-2.1 Purpose and scope

This subchapter sets forth the procedures and standards used by the Department and [sheltered workshops] **community rehabilitation programs** to defray the costs of public transportation, **personal auto,** and paratransit expenses of [clients enrolled in sheltered (extended) employment programs at sheltered workshops] **individuals with disabilities certified by the Division of Vocational Rehabilitation Services as extended employees in community rehabilitation programs.**

12:45-2.2 Definitions

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

. . .

["Division" means the Division of Vocational Rehabilitation Services in the Department of Labor.]

. . .

"Personal auto" means an automobile owned and operated by the extended employee, or an immediate family member of the extended employee.

. . .

["Sheltered workshop"] **"Community rehabilitation program"** means a facility processing a valid certificate to vend **extended employment** services to the Division issued by the Director thereof, in compliance with the rules governing [Vocational rehabilitation facilities] **Extended (Sheltered) Employment found at N.J.A.C. 12:51-6.**

12:45-2.3 Responsibilities of [sheltered workshop] **community rehabilitation programs**

(a) Each [sheltered workshop] **community rehabilitation program** shall complete, on a biannual basis, a survey of the transportation needs of each client **certified as an extended employee** (see Appendix A incorporated herein and made part of by reference).

1. Each survey shall include the [facility] **community rehabilitation program** name, the name and phone number of each person completing the survey, and the following information for each client:

i. Name, address and social security number;

ii. Mode of transportation (that is, public transportaton, **personal auto** or paratransit);

iii. Round trip mileage from residence to the [sheltered workshop] **community rehabilitation program**;

iv. Daily out-of-pocket cost; **and**

[v. Daily actual cost; and]

[vi.]**v.** Actual number of days in attendance per client during the prior six month period.

(b) Each [sheltered workshop] **community rehabilitation program with an extended employment contract** shall submit a completed survey by [May 1 and November 1] **July 15 and January 15** of each year to:

Chief of [Facilities Programs] **Rehabilitation Services**
Division of Vocational Rehabilitation Services
CN 398
Trenton, New Jersey 08625-0398

1. Failure to submit the surveys by the due dates may result in a delay in the allocation of funds to the [sheltered workshop] **community rehabilitation program**.

12:45-2.4 [Categories of expenses] **Method of payment**

(a) Upon receipt of the completed surveys, the Division shall conduct an analysis of all surveys and [establish categories of expenses] **determine the percentage of allowable expenses that can be reimbursed.** [Categories of expenses shall be established utilizing an equitable distribution of funds available for the applicable fiscal year.

(b) The categories of expenses established for fiscal year 1989 shall be as follows:

Categories of Expenses	Daily Reimbursement
1. $1.60 or less:	$1.00
2. $1.61 to $2.25:	$1.60;
3. $2.26 to $3.25:	$2.25;
4. $3.26 to $5.00:	$3.25; and;
5. $5.01 or more	$4.75.]

(b) Each certified individual with a disability will be reimbursed a percentage of his or her costs, which percentage shall be calculated based upon the ratio between the total amount of the appropriation allocated for the reimbursement of travel expenses in each fiscal year and the aggregate total of allowable reimburseable expenses submitted for that fiscal year.

[(c) Each category of expense may be subject to change during a fiscal year depending on survey results and availability of funds.]

12:45-2.5 Disbursement of funds

(a) The Department shall allocate available funds to each [sheltered workshop] **community rehabilitation program** by [June 1 and December 1] **August 1 and February 1** of each year based on their [transportation needs] **reported allowable transportation costs.**

(b) Each [sheltered workshop] **certified community rehabilitation program** shall issue checks to clients to be used to defray transportation costs by [July 1 and January 1] **August 15 and February 15** of each year.

(c) The Department shall reimburse each [sheltered workshop] **community rehabilitation program** for the reasonable administrative costs associated with the disbursement of checks to clients.

APPENDIX

[TRANSPORTATION SURVEY FOR EMPLOYEES (CLIENTS) OF SHELTERED WORKSHOPS

Facility Name: _____ Person Completing Form: _____ Telephone Number: _____

Is there an Adult Activity Center on your premises or in close proximity? Yes ____ No ____

Work Activity Center? Yes ____ No ____

Client Name	Address	SS#	Mode of Transport Public	Paratransit (include) mileage)	Time in Tranist (Roundtrip)	Distance from Facility (Roundtrip)	Daily Client out of Pocket Cost	Daily Actual Cost?/Who Pays Difference?	Number of Days in Attendance

]

TRANSPORTATION SURVEY FOR ALL NEW DVRS EE CLIENTS

ALL REQUESTED INFORMATION MUST BE PROVIDED

Period Covered: _____ **Facility Name** _____ **Persons Completing Form** _____ **Telephone Number** _____

Client Name	Address and Zip Code	SS#	Mode of Transportation	Distance From Facility (Roundtrip)	Daily Client Out of Pocket Cost	Number of Days in Attendance

APPENDIX A

[Instructions for Completing Transportation Survey for Employees (Clients) of Sheltered Workshops

A. Complete facility name, person completing survey, and telephone number.

B. Place a check mark in the appropriate blanks related to Adult Activity or Work Activity Training Centers.

C. Complete remaining survey for each client as per the following:

1. Client name, address and social security number: Complete for each eligible client (even if they do not need transportation funding assistance.)

2. Mode of transport: How does the client get to your facility? If by public transit, please use the following code to complete this section for each client:

NJ = NJ Transit
C = County Transportation
PC = Private Contractor
F = Facility Operated Transportation System
PC/F = Private Contractor Arranged by Facility
DDD = Division of Developmental Disabilities

If client drives to the facility by auto (paratransit), please indicate the number of miles the client travels round trip each day. If the client car pools, take a percentage of the miles based on the number of persons sharing the car.

3. Distance from facility: Please indicate the round trip mileage for the client from the facility.

4. Daily client out of pocket costs: Indicate how much the client pays each day and/or how much the client is billed for the daily transport. (Example: A client may be billed by a facility for a particular amount but to date has not been able to pay.)

5. Daily actual cost? Who pays the difference? Indicate the actual cost of the daily transportation and if it is not being paid by the client, who is paying for the cost.]

Instructions for completion of client lists for transportation survey

The enclosed client list is that which we have for your facility at the present time. We may have overlooked some data that we received from you, so please check the list carefully. If any clients have been placed or dropped out and are not to receive a check, please draw a single line through the entry. Please do this lightly so that we can read the information sufficiently to remove it from our system.

The critical items that we need reviewed and adjusted on this document are:

1. The daily cost to the client is to be adjusted in the column "Daily Client Out of Pocket Costs."

2. The number of days the client attended during this period should be indicated under "Number of Days in Attendance."

3. Accurate distance is critical in those instances where the client is transported by personal auto and is to be paid mileage up to a maximum of $0.25 per mile.

4. Please verify the mode of transportation on all clients in extended employment using the following codes as appropriate:

NJ = New Jersey Transit
CT = County Transportation System
PC = Private contractor
FC = Facility operated
PF = Private Contractor arranged by facility
DD = Division of Developmental Disabilities
MU = Municipal transportation system
AU = Client/Parent own auto
PA = PATH (northeast) or PATCO (South).

After verifying the accompaying list, please use the blank form to list any clients that must be added. Please fill in all the requested information: Client name, address, zip code, social security number, mode of transportation, distance from the facility, daily client out of pocket cost, and the actual number of days the individual attended the program.

Please return this material to the attention of your community rehabilitation program specialist by _____.

RULE ADOPTIONS

BANKING

(a)

DIVISION OF REGULATORY AFFAIRS

Depository Institutions
Compensation
Adopted New Rules: N.J.A.C. 3:4-2

Proposed: August 16, 1993 at 25 N.J.R. 3586(a).
Adopted: October 15, 1993 by Jeff Connor, Commissioner, Department of Banking.
Filed: October 19, 1993 as R.1993 d.565, **without change.**

Authority: N.J.S.A. 17:1-8.1, 17:9A-8.10, 27.50 and 106; and 17:12B-72.

Effective Date: November 15, 1993.
Expiration Date: August 17, 1997.

Summary of Public Comments and Agency Responses:

The Department received comments from Samuel J. Damiano, President, New Jersey Council of Savings Institutions, and from Samuel J. Malizia, Esq.

COMMENT: The regulation as proposed will provide options to those contemplating the stock alternative and, as indicated by the Department, will serve to attract the most qualified for director positions.

RESPONSE: The Department agrees, and is adopting the rules for that purpose.

COMMENT: The rule as proposed requires that the stock option plan be approved by the holders of two-thirds of the capital stock of the depository entitled to vote. This should be reduced to 50 percent to make the rule consistent with similar provisions of the IRS, OTS and SEC.

RESPONSE: The Banking Act requires two-thirds approval for stock option plans in general. N.J.S.A. 17:9A-27.50. The rule is therefore consistent with this requirement of statutory law.

Full text of the adoption follows:

SUBCHAPTER 2. COMPENSATION

3:4-2.1 Definitions

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

"Bank" shall have the same definition as provided in section 1 of P.L. 1948, c.67 (N.J.S.A. 17:9A-1).

"Depository" shall mean a bank, savings bank or savings and loan association, and includes a limited purpose trust company.

"Savings and loan association" shall mean a capital stock association established pursuant to L.1974, c.137 (17:12B-244 et seq.).

"Savings bank" shall mean a capital stock savings bank established pursuant to L.1982, c.9 (N.J.S.A. 17:9A-8.1 et seq.).

3:4-2.2 Stock option plans

(a) A bank may permit its directors, officers and employees to participate in a stock option plan established pursuant to N.J.S.A. 17:9A-27.50 et seq., and a savings bank may permit its directors, officers and employees to participate in a stock option plan established pursuant to N.J.S.A. 17:9A-8.10.

(b) A savings and loan association may permit its directors, officers and employees to participate in a stock option plan to the same extent as permitted for banks and savings banks so long as the association complies with N.J.S.A. 17:9A-27.50 et seq.

(c) A depository may not grant stock options to a director for less than the higher of the par value or 100 percent of the fair market value of the shares at the time the options are granted. A depository may not grant stock options to an officer or employee for less than the higher of the par value or 85 percent of the fair market value of the shares at the time the options are granted. Stock option plans may not provide for the payment of cash to directors by the depository upon cancellation of the options.

(d) A stock option plan must be adopted by the depository's board of directors and approved by the holders of two-thirds of the capital stock of the depository entitled to vote.

PERSONNEL

(b)

MERIT SYSTEM BOARD

Notice of Administrative Correction
Selection and Appointment
Residence Standards
N.J.A.C. 4A:4-2.11

Take notice that the Department of Personnel has discovered a printing error in the text of N.J.A.C. 4A:4-2.11 as incorporated into the New Jersey Administrative Code by the June 21, 1992 Code update. N.J.A.C. 4A:4-2.11(c) through (e) were proposed for readoption without change and readopted, their full text appearing in the notices of proposal and readoption (see 25 N.J.R. 1085(b) and 2509(a)). However, these three subsections were inadvertently omitted from the text of the rule in the June 21, 1993 Code update.

This notice of administrative correction is published in accordance with N.J.A.C. 1:30-2.7.

Full text of the corrected rule follows (addition indicated in boldface **thus**):

4A:4-2.11 Residence standards

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

(c) The Department of Personnel will review residence requirements for examination candidates. It is the responsibility of the appointing authority to review and enforce residence requirements relating to appointment and continued employment.

(d) When there is a requirement that an employee reside within a specific distance of the work site, a written request must be submitted by the appointing authority to the Department for approval of such a restriction.

1. A request must be received and approved prior to the announcement of the examination.

2. However, the Department may, in appropriate circumstances, add special residency limitations after an eligible list is promulgated.

(e) An applicant seeking to appeal a residency determination shall utilize the procedures contained in N.J.A.C. 4A:4-6.6. The applicant shall have the burden of proving his or her residence.

COMMUNITY AFFAIRS

(c)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code
Minor Work; Ordinary Repairs
Adopted Amendments: N.J.A.C. 5:23-1.4, 2.7 and 2.17A

Proposed: August 16, 1993 at 25 N.J.R. 3692(a).
Adopted: October 15, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.
Filed: October 21, 1993 as R.1993 d.580, **with a technical change** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 52:27D-124.

Effective Date: November 15, 1993.
Expiration Date: February 3, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

N.J.A.C. 5:23-2.7(b)2 to correct an error in the text as originally submitted. The phrase "removal or cutting away" is retained as "removal or cutting" as in the existing rule.

Full text of the adoption follows (deletions from proposal indicated in brackets with asterisks *[thus]*):

5:23-1.4 Definitions

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

...

"Minor work" means construction work undertaken in existing structures, requiring no prior approvals and no plan review, not altering in any way the structural members of a building and meeting the definition set forth in N.J.A.C. 5:23-2.17A.

...

5:23-2.7 Ordinary repairs

(a) Ordinary repairs to structures may be made without application or notice to the construction official.

(b) Such repairs shall not include any of the following:

1. The cutting away of any wall, partition or portion thereof;

2. The removal or cutting *[away]* of any structural beam or bearing support;

3. The removal or change of any required means of egress, or rearrangement of parts of a structure affecting the exitway requirements;

4. Any work affecting structural or fire safety;

5. Any work that will increase the nonconformity of any existing building or structure with the requirements of the regulations;

6. Addition to, or alteration, replacement or relocation of:

i. Any standpipe;

ii. Water supply, sewer, drainage, gas, soil, waste, vent or similar piping;

iii. Electrical wiring, other than wiring for a low voltage communication system in a one- or two-family dwelling; or

iv. Mechanical or other work affecting public health or general safety.

5:23-2.17A Minor work

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

(c) Minor work:

1.-3. (No change.)

4. Minor work shall also mean and include the installation of any fire detection or suppression device in any one- or two-family dwelling; installation of a radon mitigation system in an existing detached one or two-family dwelling; the installation of a burglar alarm or security system in any structure and the installation of a low voltage communication system in any structure other than a one- or two-family dwelling.

(d) (No change.)

(a)

DIVISION OF HOUSING AND DEVELOPMENT

Uniform Construction Code

Municipal Enforcing Agencies; Administration and Enforcement

Adopted Amendment: N.J.A.C. 5:23-4.5

Proposed: August 16, 1993 at 25 N.J.R. 3693(a).

Adopted: October 15, 1993 by Stephanie R. Bush, Commissioner, Department of Community Affairs.

Filed: October 21, 1993 as R.1993 d.581, **without change.**

Authority: N.J.S.A. 52:27D-124.

Effective Date: November 15, 1993.

Expiration Date: February 3, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

5:23-4.5 Municipal enforcing agencies; administration and enforcement

(a) (No change.)

(b) Forms:

1. (No change.)

2. The following standardized forms established by the Commissioner are required for use by the municipal enforcing agency:

...

F-320A	Elevator Notice
F-325	Notice of Elevator Device Sealed Out of Operation

...

3.-5. (No change.)

(c)-(j) (No change.)

ENVIRONMENTAL PROTECTION AND ENERGY

(b)

ENVIRONMENTAL REGULATION—LAND USE REGULATION PROGRAM

Coastal Zone Management

Energy Use Policies

Outer Continental Shelf Oil and Gas Exploration and Development

Adopted Amendment: N.J.A.C. 7:7E-7.4

Proposed: January 4, 1993 at 25 N.J.R. 5(a).

Adopted: October 8, 1993 by Jeanne M. Fox, Acting Commissioner, Department of Environmental Protection and Energy.

Filed: October 14, 1993 as R.1993 d.549, **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. 13:1D-1 et seq.; 13:19-1 et seq.; 13:9B-1 et seq.; and 12:5-1 et seq.

Effective Date: November 15, 1993.

Expiration Date: July 24, 1995.

Summary of Hearing Officer Recommendations and Agency Response:

On January 4, 1993, the Department proposed to amend the Coastal Zone Management Rules on Outer Continental Shelf Oil and Gas Exploration and Development so as to discourage rather than encourage the rapid exploration of these potential energy resources. The Department held a public hearing concerning the proposal on January 26, 1993, in Trenton, New Jersey, and written comments were accepted through February 3, 1993.

Robert A. Tudor, the Department's Land Use Regulation Program Administrator, served as the hearing officer at the public hearing. One member of the public, Mr. John Holtz, Associate Director of the New Jersey Petroleum Council (NJPC) attended the hearing. Mr. Holtz was present as an observer and stated that the NJPC intended to submit written comments.

Administrator Tudor recommended that the Department adopt the rules with the changes described in the Summary of Public Comments and Agency Responses below. The Department agrees with the recommendation. The hearing record may be reviewed by contacting Janis E. Hoagland, Esq., Department of Environmental Protection and Energy, Office of Legal Affairs, CN 402, Trenton, NJ 08625.

Pursuant to Federal regulations (15 C.F.R. 923.84), the Department is providing public notice of this rulemaking action. The Department considers this action to constitute Routine Program Implementation of the New Jersey Coastal Zone Management Program. This term is defined

in 15 C.F.R. 923.84 as a program change which does not involve "substantial changes in ... or to enforceable policies related to: (1) boundaries; (2) uses subject to the management program; (3) criteria or procedures for designating or managing areas of particular concern or areas for preservation or restoration; and (4) consideration of the national interest involved in the planning for and in the siting of, facilities which are necessary to meet requirements which are other than local in nature."

The Department has requested the concurrence of the Office of Ocean and Coastal Resources Management within the National Oceanic and Atmospheric Administration (NOAA) in the determination that this rulemaking action constitutes routine program implementation. Comments concerning whether or not this rulemaking action should be considered routine program implementation should be submitted by December 6, 1993 to:

Clement Lewsey
National Oceanic and Atmospheric Administration
Office of Ocean and Coastal Resource Management
1305 East West Hwy.
Silver Spring, MD 20910

Summary of Public Comments and Agency Responses:

Two parties, Margaret Okuzumi and James E. Benton, Executive Director of the NJPC, provided written comments to the Department within the comment period. Their comments are presented below in the order in which they were received.

1. COMMENT: Ms. Margaret Okuzumi of Westfield, New Jersey, commented in support of the proposed amendment, citing the following reasons: The proposed change to promote energy conservation and greater use of alternative energy at the State and Federal level is a welcome and necessary transition to decrease the State's and the nation's dependence on oil. It is important that renewable energy be more widely used because, according to calculations made by M. King Hubbard, oil reserves may be depleted in the next 50 years or sooner. Furthermore, the use of fossil fuel may have to be curtailed long before the reserves are depleted, due to the unacceptable amount of pollutants generated from their use, especially the release of carbon dioxide, which depletes the ozone and causes global warming and raises the sea level. This change will benefit the economy and environment and improve our quality of life. The risk of oil spills will be lessened. New job opportunities will be created near urban areas (where unemployment is most acute), as a result of the implementation of energy conservation measures and the development and application of alternative energy sources. Studies have shown that using energy from renewable sources is extremely labor-intensive and creates far more jobs than nuclear or any traditional fuel sources (*The Solar Job Book,* Katherine Ericson, Brick House Publishing Co., Andover, MA).

RESPONSE: The Department acknowledges this comment in support of the proposal.

2. COMMENT: Mr. James Benton, Executive Director of the New Jersey Petroleum Council (NJPC), objected to the proposed amendment for the following reasons: There is no environmental evidence to support the change. Past exploration activities have caused no environmental damage to the shoreline or to fish and wildlife habitat. The risk of oil spills is miniscule; only 0.00122 percent of oil produced has been spilled. Offshore petroleum operations are strictly regulated by 90 sets of Federal regulations and 17 major permits. Environmentally sensitive areas such as fish breeding grounds can be individually protected by excluding them from any leasing arrangements. It is unlikely that any offshore platforms, located 75 miles or more offshore, will be visible from shore.

Alternative energy sources and energy conservation cannot significantly replace or reduce the nation's dependence on oil and gas, which currently supply two-thirds of the country's energy needs. The U.S. Department of Energy projects that the demand for oil and gas will continue to grow in coming decades as the economy grows. New Jersey ranks eighth in the nation in total petroleum product consumption. New Jerseyans consume more than nine billion gallons of petroleum annually, for everything from home heating to transportation. The State, therefore, must be fully prepared to fully utilize all possible sources of energy, including potential offshore reserves of oil and natural gas.

The revised policy is contradictory to the Department's support for Assembly Bill 516, which promotes the use of natural gas as an alternative transportation fuel in New Jersey. Also, New Jersey's recreational resource and tourism development has benefitted financially from revenues generated by offshore exploration permit fees. New Jersey has received over $91 million from the Land and Water Conservation Fund for various water conservation and/or recreational facility development projects throughout the State. Last, changes in CAFRA policy have been the purview of the New Jersey legislature. Would it not be appropriate for this policy to be reviewed first by the legislature? Has this policy been prepared in consultation with the Atlantic Region Office of Minerals Management Services, U.S. Department of Interior?

RESPONSE: The Department acknowledges NJPC's position on the proposed amendments as well as on the other issues raised. The Summary of the proposal noted that the rule, as adopted, will more closely reflect New Jersey's current Energy Master Plan and will further reduce environmental threats posed by exploration activities as well as by the eventual processing, transport and use of petroleum products, specifically gasoline use. Both former Governor Kean and Governor Florio have repeatedly requested the U.S. Congress to place a moratorium on New Jersey's Outer Continental Shelf exploration because of environmental and economic concerns, citing the threats OCS activities present to the tourism and fishing industries. New Jersey has held this position for quite some time, and it was conveyed in detail to the Office of Minerals Management Services last year in response to the proposed five-year leasing program.

While the NJPC is correct that the offshore platforms would be located too far offshore to be visible to shore communities and visitors and that the past offshore exploration activities have not placed any environmentally sensitive areas in jeopardy, this is not a complete assessment of the potential environmental and economic impacts associated with OCS activities. Past experience does not guarantee that accidents will not occur in the future or that the on-shore processing and refining activities will not have any adverse environmental impacts, including visual degradation.

The Department also disagrees with the NJPC's position that the State needs to further encourage OCS exploration in order to be fully prepared for increased energy demand in the future. The exploration activities to date show that the oil and gas resources off the New Jersey coast are not commercially recoverable. The lack of readily available OCS resources is a reason to decrease the State's dependence on oil and to begin to look to all possible sources to meet future energy needs.

The revised policy does not contradict the Department's support for Assembly Bill 516, which promotes the use of alternative transportation fuels in New Jersey. Natural gas is one of several alternative fuels to be explored for its marketability. The use of alternative fuels generates less or no pollutants and, with the exception of natural gas, the fuels are renewable.

The Department agrees that New Jersey's recreation and tourism industries previously benefitted financially from offshore exploration permit revenues. However, the oil and gas industry has already determined that resources are not commercially recoverable off the New Jersey coast and has not conducted any exploratory activities over the last nine years when the previous rules were in place.

With respect to the commenter's statement that the Department should have consulted the Legislature and the Office of Minerals Management Services, the Department notes that the rules on Coastal Zone Management are administrative rules and are promulgated and amended in accordance with the Rules for Agency Rulemaking, N.J.A.C. 1:30 and the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., by the Commissioner of the Department. This administrative rulemaking process is an open process subject to public scrutiny. Moreover, as noted above, the adopted rule reflects more closely the current official position of New Jersey, which has been conveyed to the Office of Minerals Management Services a number of times over the last few years.

Summary of Agency-Initiated Changes:

The specific reference to the National Energy Strategy at N.J.A.C. 7:7E-7.4d(1) has been deleted in order to make it clear that while New Jersey may look to Federal law for guidance, the State retains full authority to make its own policies and decisions on Outer Continental Shelf oil and gas exploration and development.

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

7:7E-7.4 Energy Use Policies

(a) (No change.)

(b) Standards relevant to general energy facility siting procedure are as follows:

1. The acceptability of all proposed new or expanded coastal energy facilities shall be determined by the following review process.

2. The Department will determine the need for future coastal energy facilities according to three basic standards. The Department will prepare an Energy Report with its determination of the need for a coastal energy facility based on three required findings:

i.-iii. (No change.)

3. The Department will determine the acceptability of coastal energy facilities using this chapter supported by appropriate, technically sound analyses of alternatives.

4. Rationale: See OAL Note at the beginning of the subchapter.

(OAL NOTE: The following amendment is a change to the rationale for N.J.A.C. 7:7E-7.4(b) which, as explained in the Code, is not published as part of the Code.)

Rationale: The State's Energy and Coastal Zone Management Programs share responsibility for carrying out the energy facility siting, planning and project review. These review standards and procedures facilitate a concurrent and coordinated review of the need for and siting of energy facilities in the coastal zone by the State's Energy and Coastal Zone Management programs.

(c) (No change.)

(d) Outer Continental Shelf (OCS) Oil and Gas Exploration and Development Policy

1. Exploration of the Mid-Atlantic, North Atlantic, and other offshore areas with potential reserves of oil and natural gas is discouraged, as long as ***there are*** other viable alternatives with less or no environmental threats to the coastal environment, including energy conservation, ***which*** have not been fully explored *[and fully integrated into the National Energy Strategy]*. *[Nevertheless, should]* ***Should*** exploration occur and commercially recoverable amounts of oil or natural gas be found, development and production of offshore hydrocarbons shall be carried out according to the specific energy facility policies of this section.

2. Rationale: See OAL Note at the beginning of the subchapter.

(OAL NOTE: The following amendment is a change to the rationale for N.J.A.C. 7:7E-7.4(d) which, as explained in the Code, is not published as part of the Code.)

Rationale: The decision of the U.S. Department of Interior to lease offshore tracts for oil and natural gas exploration presents New Jersey with new onshore and marine-related environmental problems and opportunities (See Figure 15). New Jersey recognizes the national need to identify new energy supplies, but discourages the exploration of offshore oil and gas reserves as long as there are other viable alternative measures that could meet national energy needs without posing any environmental threats. These measures include demand reduction, conservation and renewable energy sources. New Jersey encourages a balanced energy use strategy which fully explores all alternatives and evaluates the viability of each in a comprehensive manner, before continuing to rely on oil, gas and other energy sources posing environmental risks.

New Jersey strongly advocates that energy conservation be fully integrated into all major governmental policies affecting economic and land use developments, because it is a cost-effective, long term measure which bears no negative environmental consequences. This is especially important in the New Jersey coastal area where the tourism based economy is closely tied to the quality of the coastal environment. Energy conservation is a key component of the New Jersey State Energy Master Plan, Transportation Master Plan and State Implementation Plan for air quality, all of which directly and indirectly affect the development pattern of the coastal area. Energy conservation and other environmentally non-threatening measures need to be fully factored into the national energy demand and supply equation, and afforded a leading role in the formulation of national energy strategy.

A number of natural gas strikes were made on tracts leased in the Mid-Atlantic OCS Region since the 1970s. These strikes did not constitute a commercial discovery. In the event that commercial quantities of natural gas and/or oil are found off the New Jersey coast, there may be considerable onshore and offshore activity during the development stage of OCS operations that is necessary for the production of these hydrocarbon resources. Development activity will diminish once production begins.

Figure 15 (No change.)

To minimize the impact of needed facilities, DEP encourages the location of OCS-related facilities, except oil and gas transportation facilities, in developed areas where the infrastructure and labor market already exist to absorb such activity.

During the construction of onshore oil and gas facilities, there may be an influx to the coastal zone of the marine service and engineering industry. This service sector office-oriented activity will be encouraged to locate in urban centers, such as Atlantic City.

(e)-(s) (No change.)

(a)

COMMISSION ON RADIATION PROTECTION

Notice of Administrative Correction
Medical Diagnostic X-ray Installations
Adopted New Rules: N.J.A.C. 7:28-15

Take notice that the Department of Environmental Protection and Energy has discovered an error in the notice of adoption for the above-referenced new rules, published in the October 18, 1993 New Jersey Register at 25 N.J.R. 4770(a). In the paragraph explaining the Commission-initiated change upon adoption at N.J.A.C. 7:28-15.4(f)10ii (see 25 N.J.R. 4776), certain mammography linearity requirements were erroneously stated as applicable to equipment manufactured after May 3, 1993. As reflected in the adopted rule provision at 25 N.J.R. 4784, such requirements are actually applicable to equipment manufactured after May 3, 1994. This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

HEALTH

(b)

DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SERVICES

Pilot Low-Cost Spaying and Neutering Clinic Surgery Fees
Adopted New Rules: N.J.A.C. 8:23-6

Proposed: July 19, 1993 at 25 N.J.R. 3116(a).
Adopted: October 19, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health.
Filed: October 20, 1993 as R.1993 d.568, **without change**.

Authority: N.J.S.A. 4:19A-11.

Effective Date: November 15, 1993.
Expiration Date: December 13, 1994.

Summary of Public Comments and Agency Responses:

The Department received comments from Mr. Richard J. Alampi, Executive Director, New Jersey Veterinary Medical Association, concerning the rule proposal.

COMMENTS: The New Jersey Veterinary Medical Association (NJVMA) strongly feels that to allow the Pilot Clinic to raise its fees at this time is wrong. Private practitioners who participate in the Department's Animal Population Control (APC) Program enjoy none of the tax-exempt privileges that accrue to the Pilot Clinic and are not being given the same opportunity to raise their fees. The proposed increase reflects an average increase of 15.3 percent, which is a very generous subsidy, according to the commenter.

The commenter continues by stating that the proposed fee increase would also provide for a price range for spaying of female dogs from $40.00 to $55.00. This is more than twice the cost for the same surgery done under the adoption provisions of the APC Fund, and calls to question whether the surgery would truly continue to be "low-cost."

The NJVMA further suggests that before appropriating fees from the general treasury, the Pilot Clinic should increase its fundraising efforts. Figures published in the New Jersey Register show that in FY 1992, the Pilot Clinic generated $135,010 in surgical fees, and received $85,000 in State grant funding, for a total of $220,010. Operating costs totaled $238,000, leaving a shortfall of almost $18,000. This does not appear

an unreasonable amount to ask the contractor, People For Animals, Inc., to raise via contributions or donations, and should be emphasized before raising fees.

The NJVMA also questions if the contract for operating the Pilot Clinic has been put out to bid, since the contract was awarded to People For Animals, Inc. in 1984. Perhaps another contractor would be able to operate the clinic within the existing budget provided by surgical fees and grants.

RESPONSE: Since the inception of the Pilot Clinic operations in 1984, there have been only two requests from the Board of Directors for increases in fees with the first being in 1989 for $5.00, and this proposed increase for $5.00 in selected categories. In contrast, the veterinarians participating in the APC Program have realized a number of increases in their fees since the inception of program operations in 1984. Specifically, over the four year period of January 1989 through December 1992, veterinarian fees have increased by 20 percent for those private practitioners participating in the Department's APC Program.

It is inappropriate to compare the fee cost to the consumer for Pilot Clinic services to the copayment fee required of consumers eligible to participate in the APC Program. The Pilot Clinic fee represents the total cost of surgery and all immunizations, including rabies vaccination. In contrast, the copayment fee provided by the consumer is set by statute and is not the total cost for the same services, nor does the surgical cost include reimbursement to veterinarians for immunizations.

As a point of clarification, the Pilot Clinic funds are derived from a $0.20 surcharge on all licensed dogs and are to be used exclusively for the operations of the Pilot Clinic; hence, no appropriations are required from the general treasury.

During Fiscal Year 1993, the Pilot Clinic completed 4,245 surgeries, of which 2,581 surgeries are in the specific categories of the requested fee increases. Based on the same number of surgeries, the increase would provide an additional $12,905 in income and reduce the projected shortfall of approximately $18,000 to approximately $5,000, which is more reasonable to expect the contractor to contribute through such means as fundraising.

The stated intent of the enabling legislation was to determine the feasibility of opening additional clinics throughout the State. Inherent in the charge is the determination as to whether or not a Pilot Clinic can become self sufficient. In order to properly assess this, it is necessary to award this grant through a noncompetitive process and it is the Department's opinion that it is not feasible or appropriate to open additional Pilot Clinics or change the existing Pilot Clinic at this time.

AGENCY NOTE: The Department has discovered an error in the proposed rule Summary published on July 19, 1993 in the New Jersey Register, and corrects the statutory citation regarding immunization from N.J.S.A. 4:19-11e to N.J.S.A. 4:19-11c.

Full text of the adoption follows:

SUBCHAPTER 6. PILOT LOW COST SPAYING AND NEUTERING CLINIC SURGERY FEES

8:23-6.1 Fees

The public may have dogs and cats spayed or neutered, as the case may be, in a humane manner by a licensed veterinarian at the pilot clinic upon payment of the following fees:

For spaying females dogs weighing	
Not more than 40 pounds	$40.00
41 to 60 pounds	45.00
Over 60 pounds	50.00
For spaying female dogs which are pregnant or in heat	55.00
For neutering male dogs weighing	
Not more than 40 pounds	30.00
41 to 65 pounds	35.00
Over 65 pounds	40.00
For spaying female cats of any weight	35.00
For spaying female cats which are pregnant or in heat	35.00
For neutering male cats of any weight	30.00

8:23-6.2 Immunizations included in fees

The fees shall include immunization of dogs against distemper, hepatitis, and leptospirosis and the immunization of cats against feline panleucopenia, pneumonitis and rhinotracheitis, which immunization shall be given at least 10 days prior to surgery on animals not previously immunized.

(a)

HOSPITAL REIMBURSEMENT

Hospital Financing

Adopted Amendments: N.J.A.C. 8:31B-1.1, 1.2, 3.1, 3.3, 3.11, 3.16, 3.17, 3.24, 3.26, 3.43, 4.2, 4.3, 4.4, 4.6, 4.12, 4.15, 4.16, 4.21, 4.24, 4.25, 4.31, 4.32, 4.33, 4.34, 4.54, 4.59, 4.61, 4.62, 4.64, 4.65, 4.66, 4.67, 4.72, 4.76, 4.77, 4.98 and 4.131

Adopted Repeals: N.J.A.C. 8:31B-3.2, 3.4, 3.5, 3.6, 3.7, 3.9, 3.10, 3.15, 3.18, 3.19, 3.20, 3.21, 3.22, 3.23, 3.27, 3.28, 3.29, 3.30, 3.31, 3.32, 3.33, 3.34, 3.37, 3.38, 3.39, 3.40, 3.41, 3.42, 3.44, 3.45, 3.51, 3.52, 3.55, 3.57, 3.63, 3.64, 3.65, 3.71, 3.72, 3.73, 3.74, 3.75, 3.87; N.J.A.C. 8:31B-5; Appendices I, III, IV, V, VI, VII, VIII and XI

Adopted Repeal and New Rule: N.J.A.C. 8:31B-4.1

Proposed: July 19, 1993 at 25 N.J.R. 3117(a); see also 3566(a), August 2, 1993.

Adopted: October 19, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner of Health (with approval of the Health Care Administration Board).

Filed: October 21, 1993 as R.1993 d.593, **with substantive changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq.

Effective Date: November 15, 1993.

Expiration Date: August 17, 1995.

Summary of Public Comments and Agency Responses:

COMMENTER: North Jersey Physician's Review

COMMENT: N.J.A.C. 8:31B-3.76, Necessity and appropriateness of health care services. The commenter believes that there is a typographical error listing this section as proposed for repeal.

RESPONSE: N.J.A.C. 8:31B-3.76 was erroneously listed as a proposed repeal in the heading of the notice. A correction appears in the New Jersey Register on August 2, 1993, at 25 N.J.R. 3566(a), removing this section from the repeal listing.

COMMENTER: New Jersey Manufacturer's Insurance Company

COMMENT: Additional rules should be proposed in support of P.L. 1992, Chapter 160, the Health Care Reform Act, to prohibit cost shifting and to establish standards for negotiated discounts and contracts between payers and hospitals.

RESPONSE: This comment is not relevant to the scope of the current proposal. The Department recommends no change to this proposal as a result of this comment, but will review the comment further and share it with the Essential Health Services Commission, established under the Health Care Reform Act.

Summary of Agency-Initiated Changes:

The Department recognizes that amendments to N.J.A.C. 8:31B-4.1 and 4.2 are required for clarification of the purpose of Subchapter 4, Financial Elements and Reporting, and for the removal of all reference to hospital payment rates to be in conformance with the Health Care Reform Act of 1992, P.L. 1992, Chapter 160.

This oversight is being corrected by including changes to N.J.A.C. 8:31B-4.1 and 4.2 in the adoption of the proposed amendments to N.J.A.C. 8:31B. These additional amendments are only minor substantive changes which do not significantly enlarge or curtail the scope of the rule and its burden, enlarge or curtail who or what will be affected by the rule, or change what is being prescribed or mandated by the rule.

N.J.A.C. 8:31B-4.1, Purpose, required a change in the overall focus of the subchapter and language modification to be in conformance with

the Health Care Reform Act of 1992, regarding the elimination of the determination of hospital payment rates. Therefore, the rule is rewritten for clarity.

N.J.A.C. 8:31B-4.2, Functional versus responsibility reporting, contained a reference to hospital payment rates which is no longer applicable and appropriate language is inserted.

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

CHAPTER 31B
HOSPITAL FINANCING

SUBCHAPTER 1. GENERAL PROVISIONS

8:31B-1.1 Purpose and scope

The purpose of this chapter is to satisfy the requirements of the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187; and P.L. 1992, c.160, and support the public policy of the State that hospital and related health care services of the highest quality, of demonstrated need, efficiently provided and properly utilized at a reasonable cost, be available to inhabitants of the State.

8:31B-1.2 Definitions

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

. . .

"Base year" means the year from which historical cost data are utilized.

"Current Cost Base" means the actual costs and revenue of the hospital as identified in the Financial Elements in the base reporting period.

"Equalization Factor" means the factor that is calculated based on defined Labor Market Areas and multiplied by hospital costs to permit comparability between differing regional salary costs.

"Financial Elements" means those items of revenue, expenses and other data defined in N.J.A.C. 8:31B-4 for reporting to the Department of Health.

. . .

"Preliminary Cost Base" means the estimated revenue a hospital may collect based on an approved schedule of rates which includes DRG rate amounts and indirect costs not included in the all-inclusive rate. Those indirect costs will either be the dollar amount specified or the estimated amount determined by a specific percentage adjustment to the rate.

"Reporting Year" means the year in which current financial and statistical data is being reported.

. . .

SUBCHAPTER 3. FINANCIAL MONITORING AND REPORTING REGULATIONS

8:31B-3.1 Statement of purpose

The following financial monitoring and reporting rules in conjunction with Financial Elements (N.J.A.C. 8:31B-4), the Uniform Cost Reporting (N.J.A.C. 8:31A-5.5) and the Rules on Hospital Reporting of Uniform Bill—Patient Summaries regulations (N.J.A.C. 8:31B-2), constitute the minimum necessary steps for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160. These regulations should provide an environment in which to move towards the objectives of an accurate system of monitoring and reporting. This system meets the purpose of the law, to insure the citizens of New Jersey economical provision of necessary and appropriate medical services of the highest quality.

8:31B-3.3 Uniform Reporting: Current Costs

(a) The Commissioner shall collect and review the actual costs for the institutions as reported in accordance with the Financial Elements and Reporting (N.J.A.C. 8:31B-4). Costs so reported shall be subject to revision due to subsequent audits in accordance with N.J.A.C. 8:31B-3.17.

(b) Late submission of current cost data, as defined in N.J.A.C. 8:31B-4.6(c), including Audited Financial Statements, will result in penalties of $200.00 per working day past the appropriate submission date.

8:31B-3.11 Same day surgery

(a) (No change.)

8:31B-3.16 Current Cost Base

(a) A hospital's Current Cost Base is defined as the actual costs and revenue as identified in the Financial Elements in the base reporting period as recognized by the New Jersey Department of Health.

(b) The Current Cost Base is also used as the basis for the health care (hospital) analysis and reporting system.

(c) (No change in text.)

8:31B-3.17 Financial elements reporting audit adjustments

(a) The aggregate Current Cost Base is developed from financial elements reported to New Jersey State Department of Health and includes:

1. (No change.)

2. Less net income from specified sources (as defined in N.J.A.C. 8:31B-3.25); and

3. Capital Facilities Costs: Capital cash requirements (as defined in N.J.A.C. 8:31B-4.21).

(b) All reported financial information shall be reconciled by the hospital to the hospital's audited financial statement. In addition, having given adequate notice to the hospital, the Department of Health may perform a cursory or detailed on-site review at the Department's discretion of all financial information and statistics to verify consistent reporting of data and extraordinary variations in data relating to the development of the Current Cost Base (CCB). Any adjustments made subsequent to the financial review (including Medicare and Medicaid audits and New Jersey State Department of Health reviews) shall be brought to the attention of the Commissioner by the hospital, the Department of Health, appropriate fiscal intermediary or payer where appropriate and shall be applied proportionately to the Cost Base.

(c) Hospitals shall submit a complete list of exceptions to the proposed audit adjustments, together with appropriate written documentation, within 60 days of receipt of the Department's written summary of these adjustments, or these adjustments shall be implemented in accordance with (b) above. Consideration shall be given only to documentation submitted in accordance with this schedule.

8:31B-3.24 Off-site primary care

The Commissioner may establish demonstration projects involving hospital-affiliated off-site outpatient facilities providing primary care under an agreement with the Department of Health. For hospitals selected to participate in such programs, there may be reporting requirements, as defined in rules by the Department of Health, to evaluate these programs.

8:31B-3.26 Update factors

(a) Economic Factor: An economic factor shall be calculated for each hospital. It shall take into account the level of hospital expenses and replacement cost of major moveable equipment, using the cost components reported to the New Jersey State Department of Health. The economic factor is the measure of the change in the prices of goods and services used by New Jersey hospitals. The economic factor shall be based, as far as possible, on recorded price changes. For that part of the period covered by the economic factor for which recorded prices are unavailable, the economic factor shall be based on the best available forecast of price trends.

1. The economic factor shall be determined by the Commissioner of Health prior to the beginning of each year.

2. The economic factor calculation shall include the most current measure of inflation/deflation and will reflect changes in a fixed market basket of goods as determined by the Commissioner. The economic factor should not take into account changes in technology or disease entities as these are adjusted through the technology factor.

(b) Cost Change Factor: An actual cost change factor shall be calculated for each hospital, in accordance with N.J.A.C. 8:31B-4. It shall take into account the level of hospital expenses and replacement costs of major moveable equipment, using the cost components reported to the New Jersey State Department of Health. The actual cost change factor is the actual measure of the change in the prices of goods and services used by New Jersey hospitals, to be based upon reported expenses.

(c) Technology Factor: The technology factor shall be based on the Scientific and Technological Advancement Allowance recommended annually to the Secretary of the United States Department of Health and Human Services by the Prospective Payment Assessment Commission (ProPAC). The factor shall be composed of the proportion of incremental operating costs associated with ProPAC's identified cost increasing technologies. Allowances for technologies not included in the technology-specific projections, less the proportion of incremental operating costs of cost-decreasing technologies identified by ProPAC will be included, if available.

8:31B-3.43 Reporting of charges

(a) A hospital shall submit to the Commissioner a copy of its charges in use during the current year for review and monitoring purposes.

(b) A hospital must notify the Commissioner of any charges adjusted throughout the year which alter overall estimates of net revenue to be collected.

SUBCHAPTER 4. FINANCIAL ELEMENTS AND REPORTING

8:31B-4.1 Purpose

*[(a) "In order to provide for the protection and promotion of the health of the inhabitants of the State, promote the financial solvency of hospitals and similar health care facilities and contain the rising cost of health care services, the State Department of Health, which has been designated as the sole agency in this State for comprehensive health planning under the National Health Planning and Resources Development Act (Federal Law 93-641) as amended and supplemented, shall have the central, comprehensive responsibility for the development and administration of the State's policy with respect to health planning care services, and health care facility cost containment programs." (Health Care Facilities Planning Act of 1971 as amended 1978, 26:2H-1).

(b) "To establish and maintain a fair and equitable system for determining (hospital) payments, the Commission shall require each health care facility to report such financial, statistical and patient information as may be required, in accordance with a uniform system of reporting . . ." (26:2H-10d). This manual is intended to implement these provisions of Health Care Facilities Planning Act pertaining to health care services provided by hospitals.]*

***(a) The purpose of this subchapter is to provide the basis for a standardized system of reporting the financial elements to be used in conjunction with the Hospital Reporting of Uniform Bill-Patient Summaries regulation (N.J.A.C. 8:31B-2), the Financial Reporting and Monitoring regulation (N.J.A.C. 8:31B-3) and the Uniform Cost Reporting rule (N.J.A.C. 8:31A-5.5) for implementing the Health Care Facilities Planning Act, P.L. 1971, c.136 as amended by P.L. 1978, c.83; P.L. 1991, c.187 and P.L. 1992, c.160.**

(b) The Commissioner shall require each general acute care hospital to report cost, revenue and statistical information in accordance with the uniform system described in this subchapter. This information is critical and is required to support the Department's public health activities which include planning, licensing, providing information to consumers and other interested parties and monitoring hospital costs and revenues.*

8:31B-4.2 Functional versus responsibility reporting

(a) (No change.)

(b) Expenses, revenues and other data reported in a manner consistent with the definitions included herein will provide a sound basis for the establishment of *[hospital payment rates]* ***a uniform system of reporting***. This manual, however, is not requiring that institutions adopt this functional reporting system for their internal management reports, so long as institutions maintain the ability to report data with reasonable accuracy in accordance with the functional definitions and expense and revenue classifications defined herein.

(c) A hospital should structure its accounts for the purpose of managing a sound cost-effective and financially viable organization. In many instances, principally due to various budgetary control objectives, this goal may be better achieved through recording of expenses and revenues on a responsibility basis. However, it is highly unlikely that expenses and revenues recorded on a responsibility basis can be reported "as is" on the prescribed uniformed functional basis. This will necessitate the recast of expenses, revenue and statistics per N.J.A.C. 8:31B-4. Various reporting schedules provide the hospital with the opportunity to insure that the financial data used to develop the financial elements of the current Cost Base, despite the recasts and allocations involved, are equivalent to the hospital's own audited financial statements. A working knowledge of the principles, concepts and definitions included herein, especially with regard to the inclusion of specific functions within reporting centers and of the natural classifications of expense, is necessary for a hospital's accurate compliance with these reporting requirements.

8:31B-4.3 Prescribed reporting principles

(a) The reporting principles and concepts described in this chapter have been drawn from existing systems wherever possible.

(b) (No change.)

8:31B-4.4 Accounting entity

(No change in text.)

8:31B-4.6 Reporting period

(a) The basic reporting period is the 12 consecutive calendar months utilized for Medicare.

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

8:31B-4.12 Basis of valuation

(a) (No change.)

Recodify existing (c)-(f) as (b)-(e) (No change in text.)

8:31B-4.15 Revenues and deductions from revenue

(a) If a hospital receives less than its full charges for the services it renders, it shall report to the Department both the gross revenue and revenue "adjustments" resulting from failure to collect full charges for services provided. These revenue adjustments are called Deductions from Gross Revenue. The specific deductions required for reporting Revenue Related to Patient Care, as defined in N.J.A.C. 8:31B-4.32 are defined in (a)1 through 11 below. Any individual allowance must be reported in only one of the 10 deduction categories and three contra categories (although individual transactions may be distributed among several if appropriate):

1. (No change.)

2. Prompt payment discounts: These adjustments are the difference between charges and payments received due to the prompt payment of a bill.

3. (No change.)

4. Courtesy adjustments: These deductions represent adjustments from charges for services rendered to any individual other than employees of the hospital and not otherwise more appropriately categorized, including any patient accounts written off contrary to the hospital's formal policies relative to credit, bad debts and indigency care.

5. (No change.)

6. Medical denials: These deductions represent amounts not due from patients or third party payors because of a ruling by appropriate utilization review or certification processes which determine that the services rendered were not medically appropriate or necessary, but excluding medical denials classified as Nursing Home Placement.

7.-11. (No change.)

(b) (No change.)

8:31B-4.16 Fund accounting

(a)-(b) (No change)

(c) Funds fall into four categories: Unrestricted Funds, Donor Restricted Plant and Equipment Fund, Specific Purpose Funds and

Endowment Funds. The accounts within each fund are self-balancing, and each fund constitutes a separate subordinate accounting entity. This subsection outlines the conditions and events which require separate accountability within the established funds.

1. Unrestricted Funds are used to account for all monies not restricted by donors or grantors in accordance with the rules set forth in this section. Two funds are to be established for unrestricted funds:

i. (No change.)

ii. Board Designated Funds are unrestricted funds which have been designated for specific purposes by the hospitals governing board. The board retains the right to undesignated such funds. The amount of such board designated funds for capital replacement and renovation as well as the sources and applications of all Board Designated Funds shall be reported annually to the Department of Health per N.J.A.C. 8:31B-4.13.

2. Restricted Internally Generated Major Moveable Equipment Replacement Fund ("Equipment Fund") is a fund to be used to account for the portion of all Net Revenues Related to Patient Care for the leasing, depreciation or replacement of major moveable equipment.

i. Income from the investment on the fund's assets shall also be credited to this fund, net of any income taxes attributable to such income. Investments are to be reported at market value, and unrealized gains and losses are to be reported as income or loss each period.

ii. (No change.)

3.-6. (No change.)

8:31B-4.21 Accounting for capital facilities cost

(a)-(g) (No change.)

(h) Any changes in debt financing shall be reported to the Commissioner as they occur.

8:31B-4.24 Self insurance

(a) (No change.)

(b) It is required that where self-insurance for other than those items listed above is elected to be used by a facility, the method should conform with the following:

1. Self-Insurance Fund: The hospital or pool established a fund with a recognized independent fiduciary such as a bank or a trust company. The hospital or pool and fiduciary enter into a written agreement which includes all of the following elements:

i.-ii. (No change.)

iii. Payments by Fiduciary: The agreement must provide that withdrawals must be for malpractice and comprehensive general patient liability losses only and those expenses listed in (b)4 below. Any rebates, dividends, etc., to the hospital from the fund will be used to reduce allowable cost.

iv.-v. (No change.)

2.-4. (No change.)

8:31B-4.25 Related organizations

(a) Auxiliaries, guilds, fund raising groups and other related organizations frequently assist hospitals. Such organizations are independent if they are so characterized by their own charter, by-laws, tax-exempt status and governing board or a sufficient combination of these characteristics to demonstrate their independent existence from the hospital. The financial reporting of these organizations should be separate from or combined with reports of the hospitals in accordance with the AICPA's Hospital Audit Guide, as amended and supplemented, available from the AICPA Order Department, P.O. Box 2209, Jersey City, N.J. 07303.

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

(d) At the Department's request relevant information reported to the Department may include:

1.-5. (No change.)

8:31B-4.31 Financial elements generally

The financial elements shall include the cost of the following, as defined in regulations proposed by the Commissioner and approved by the board: direct patient care principal and interest payments; paid taxes, excluding income taxes; education, research and training programs, not otherwise paid for by the State; the provision of health care services to individuals unable to pay them for reasons of indigency; bad debts, provided adequate recovery procedures are followed; preservation, replacement and improvement of facility and equipment subject to appropriate planning requirements; reasonable working capital . . . and where applicable and appropriate, reasonable return on investment where a hospital is operating efficiently and effectively.

8:31B-4.32 Services related to patient care

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

(d) The Commissioner shall issue a public report on reimbursement for services purchased from vendors that are in violation of State certificate of need regulation.

8:31B-4.33 Direct patient care

Direct Patient Care is the provision by a hospital of medically necessary and appropriate health care services.

8:31B-4.34 Paid taxes

Taxes are monies paid to a governmental unit for conducting business related to direct patient care within its jurisdiction. Taxes related to financing of operations through the issuance of bonds, property transfers, issuance or transfers of stocks, and the like, are not classified as taxes; rather, they are to be amortized or depreciated with the cost of the security or asset. Sales and real estate taxes paid by a hospital in the provision of Services Related to Patient Care are to be included as Paid Taxes. All sales and real estate taxes for Services Related to Patient Care are to be reported in the General Administrative Services cost center and also reported separately from other classification of expense. Employment related taxes, such as FICA, Unemployment Compensation, and Worker's Compensation, are to be classified as employee fringe benefits for all employees, including hospital based physicians. Monies received by a hospital which chooses to self-insure in lieu of payments of Unemployment Compensation taxes and the associated administrative costs of such a self insurance program are included as financial elements and classified as employee fringe benefits, if such monies are reasonably related to the hospital's unemployment compensation experience.

8:31B-4.54 Employee Fringe Benefits

Employee Fringe Benefits are amounts paid to or on behalf of, an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death. Fringe Benefits associated with physicians are to be reported with physician's compensation. Pensions, annuities and deferred income arrangement costs for past and current services are to be accounted for and reported in accordance with Employee Retirement Insurance and Security Act (ERISA) and Internal Revenue Service (IRS) requirements. Employee Fringe Benefits include FICA, State and Federal unemployment insurance, disability insurance, life insurance, employee health insurance, retirement (net of actuarial and realized gains on the investment of related funds), worker's compensation insurance, other payroll related employee benefits, tuition reimbursement and other training, moving expenses of new employees of a non-recurring nature, the cost of providing free or subsidized meals or cost to the employee at less than charges to employees, employee parking lot costs net of any revenue received for operation of facility, and other non-payroll employee benefits. The cost of providing health care services to employees is included in classifications of expense in various cost centers providing the funds. Where a hospital elects to self-insure for worker's compensation or unemployment insurance, costs reported should be the amounts set aside for that accounting period plus associated administrative costs, where a separate fund has been established, to the actual amounts of claims paid during the accounting year if a fund is not established. (See N.J.A.C. 8:31B-4.24.) Where a hospital provides free or subsidized health care services to employees or physicians, the hospital's customary charges should be generated and accounted for separately as personnel health allowances. (See N.J.A.C. 8:31B-4.15.) In order to preserve comparability of hospital expenses for provision

of direct patient care, purchased employee health insurance expenses are reported as a separate cost center and not distributed to the labor costs of each center. Employee Fringe Benefits are assigned to the cost center in which the employee's compensation is reported on the following bases per N.J.A.C. 8:31B-4.131.

Benefit	Basis of Assignment
FICA-non-physician physician	Direct Cost
All other Payroll Related Benefits including Unemployment Insurance, Disability Insurance, Worker's Compensation and Pension and Retirement	Salaries
Life Insurance	Salaries or FTEs
Employee Education and Training	FTEs
Room and Board	FTEs
Cafeteria	FTEs
Parking Lot	FTEs

8:31B-4.59 Major Moveable Equipment

Major Moveable Equipment, as defined in N.J.A.C. 8:31B-4.21 are expenses to be included in the costs of each center at historical depreciation costs (or both owned and capitalized leased equipment) and operating lease expenses. Interest expense incurred through purchase or capitalized leases of Major Moveable Equipment is not included with Major Moveable Equipment costs and is reported per N.J.A.C. 8:31B-4.66(e).

8:31B-4.61 Reports of costs and revenues

(a) Expenses incurred and revenues generated by a hospital for items not included in the definitions of Services Related to Patient Care (i.e., Routine Services. Ambulatory Services, Ancillary Services, Patient Care General Services, and Institutional Services) are classified as either other operating expenses and revenues (determined per N.J.A.C. 8:31B-4.131) or non-operating revenue and are to be accounted for separately to determine if and how they will be applied to Costs Related to Patient Care and the Capital Facilities Allowance to determine the hospital total financial elements or the Current Cost Base. There are three cases into which income is classified:

1. Case A—Expenses and revenues related to activities which the hospital has selected to engage in but which are not an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.

2. Case B—Expenses and revenues related to activities which the hospital has elected to engage in and which are an integral part of, or necessary for, the provision of patient care. Such expenses and revenues are netted against each other.

3. Case C—Expenses and revenues related to activities which are specifically included under N.J.A.C. 8:31B-4.62 through 4.66. Expenses and revenues are not netted against each other.

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

8:31B-4.62 Excluded Health Care Services

(a) Non-Acute Care Services provided by a hospital such as skilled nursing facilities (approved or unapproved); intermediate care facilities, residential care, long term psychiatric care, long term rehabilitation and intermediate care services are not properly acute hospital functions, and hence are excluded and treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (i.e., Medicare cost funding SSA-2552 or SSA-2551) and such costs should be excluded from Costs Related to Patient Care by cost center per N.J.A.C. 8:31B-3.19(c) and 3.24.

(b)-(e) (No change.)

(f) Excluded Ambulatory Services: Outpatient Renal and Home Dialysis. The cost and revenue related to these services are to be treated as Case C. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect costs shall be excluded from Costs Related to Patient Care.

(g) Excluded Ambulatory Services: HealthStart Maternal Care Health Support Services. The revenues and expenses associated with the provision of these services shall be treated as Case C, netted against each other.

(h) Excluded Ambulatory Services: HealthStart Pediatric Continuity of Care. In Hospitals with salaried pediatricians, revenues and expenses associated with non-institutional Medicaid capitated fee shall be treated as Case C and netted against each other.

(i) Mobile Intensive Care Unit (MICU) Services provided after November 1, 1987: The cost and revenue related to these services are to be treated as Case C, revenues and expenses are netted. Sufficient accounting records should be maintained to account for the costs of such operations (that is, Medicare cost report HCFA-2552) and such direct and indirect cost shall be excluded from Costs Related to Patient Care.

8:31B-4.64 Sales and services not related to patient care.

(a)-(e) (No change.)

(f) Gift and Coffee Shops revenue and expense (including sales tax expense) as well as other activities which may be supported by volunteers are excluded from Services Related to Patient Care (Case C).

(g) (No change.)

(h) Parking lot or parking garage expenses and revenues at the site of the hospital are to be netted and the remainder apportioned between employees and others per N.J.A.C. 8:31B-4.131. The provision of parking facilities to:

1.-2. (No change.)

3. Others are included (Case B) if the hospital's charge for parking is not substantially inconsistent with other parking facilities in the community where the hospital is located.

i. (No change.)

8:31B-4.65 Patient convenience items

(a)-(e) (No change.)

(f) Private Room Differential Income above a hospital's most common charge for a semi-private room for similar routine services, when specifically requested by the patient is excluded and treated as Case C. Where ordered by the attending physician for medical necessity, income is excluded and treated as Case C. Hospitals should maintain separate revenue classifications for medically necessary and patient convenience private room revenue.

8:31B-4.66 Administrative items

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

(d) Gains on pension reversions are included as Services Related to Patient Care and, as such, shall be treated as Case B and offset against Costs Related to Patient Care.

8:31B-4.67 Non-operating revenues (net of expenses)

(a)-(i) (No change.)

(j) Interest income from financial charges on delinquent accounts receivable shall not be included in Costs Related to Patient Care. Income shall be treated as a Case C item.

8:31B-4.72 Medical-Surgical Acute Care Units (MSA)

(a) Function:

1. (No change.)

2. All revenue generated from charge differentials between private and semi-private rooms (except those assigned for medical necessity) is to be reported here, and also as a reconciliation per instructions in N.J.A.C. 8:31B-4, Part IV. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

3. (No change.)

(b) (No change.)

8:31B-4.76 Burn Care Unit (BCU/ICU)

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

8:31B-4.77 Intensive Care Units (ICU/BCU)

(a) Function:

1. Intensive Care Units provide nursing care to patients who, because of surgery, shock, trauma, serious injury or life threatening conditions, require intensified comprehensive observation and care. These units are staffed with specially trained nursing personnel and

contain specialized equipment for patient monitoring and life support systems. Intensive Care Units include Stroke Care, Pediatric, Intensive Care, Burn Care Unit (BCU), Medical and Surgical Intensive Care and mixed Intensive Care-Coronary Care Units, but exclude units solely designated 25 Coronary Care Units or Neo-Natal Intensive Care Units. Medical and Surgical Supplies should be reported in accordance with N.J.A.C. 8:31B-4.55.

2. (No change.)

(b) (No change.)

8:31B-4.98 Physical Therapy (PHT)

(a) Function:

1. Physical Therapy is a service employing therapeutic exercise and massage, and utilizing effective properties of light, heat, cold, water, and electricity in diagnosis and rehabilitation of patients with neuromuscular, orthopedic, and other disabilities under the medical direction of a physiatrist or other qualified physician. Physical Therapy services include the provision of clinical and constructive services and the direction of patients in the use, function, and care of braces, artificial limbs, and other devices. This center includes the cost of physical therapy related medical supplies, materials and equipment not requisitioned from Central Supply Services and for which a separate charge is not made to a patient.

2.-3. (No change.)

(b) (No change.)

8:31B-4.131 Financial Elements Report

The Commissioner of Health shall approve Financial Elements Report forms and reporting instructions consistent with the five Parts of the Financial Elements and Reporting Regulations for completion by all New Jersey hospitals. The Commissioner may refine these report forms for research purposes by adding, modifying, or changing cost centers.

(a)

HOSPITAL REIMBURSEMENT

Charity Care Audit Functions

Adopted Repeal: N.J.A.C. 8:31B-4.41

Adopted New Rules: N.J.A.C. 8:31B-4.41 through 4.41N

Proposed: August 16, 1993 at 25 N.J.R. 3707(a).

Adopted: October 19, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner, Department of Health (with the approval of the Health Care Administration Board).

Filed: October 21, 1993 as R.1993 d.592, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: P.L. 1992, c.160 and N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5b and 25:2H-18(d).

Effective Date: November 15, 1993.

Expiration Date: August 17, 1995.

Summary of Public Comments and Agency Responses:

Written comments were received from: Victoria Wicks, Chairperson, Essential Health Services Commission; Jacob C. Toporek, Chairman, Violent Crimes Compensation Board, State of New Jersey; Joseph M. Lemaire, President, Health Financial Management Association; Leighton Holness, Senior Attorney, Legal Services of New Jersey, Inc.; Gregory A. Alban, Director of Finance, The Mountainside Hospital; Cathy Worek and Maria Casale, Helene Fuld Medical Center; Jennifer Schertl, CPA, Vice President, Finance and Chief Financial Officer, Holy Name Hospital; Timothy G. Devlin, CPA, JD, Assistant Vice President of Finance, Our Lady of Lourdes Medical Center; Stella Visaggio, Assistant Vice President of Finance, Clara Maass Medical Center; Thomas J. Black, CPA, St. Joseph's Hospital and Medical Center; Joseph Aquilante, Chairman, Finance Committee, Hospital Alliance of New Jersey; Peggy Stavitz, Co-Chair, Carole Meseroll, Co-Chair, Charity Care Policy Committee on behalf of American Guild of Patient Account Managers; Dennis J. Hemenway, President, New Jersey Patient Account Managers Association; Carole Meseroll, CPAM, Director of Patient Accounts, Peggy Stavitz, Compliance Review Coordinator, Community Medical Center; Vincent M. Riccitelli, Director of Reimbursements, Cathedral Healthcare System, Inc.; NJHA, Joseph G. Bezek, Director of Finance, St. Francis Medical Center (Trenton); Joseph R. Samples, Jr., Vice President, Financial Services, Overlook Hospital; Brian McIndoe, Senior Vice President of Finance, Pascack Valley Hospital; Philip A. Besler, CPA, President, Besler & Company, Inc.; Frank Villares, Vice President/Finance, Elizabeth General Medical Center; James P. Lawler, Senior Vice President, Jersey City Medical Center; Joseph F. Suozzo, Department of the Public Advocate; Arthur W. Ellermann, Executive Vice President-Finance, Newark Beth Israel Medical Center; Orestes Varona, Cooper University Medical Center.

COMMENT: Commenters claimed that the proposed rule (N.J.A.C. 8:31B-4.41D(b)) requiring verification of insurance coverage is not practical or cost-effective. One commenter requested that the Department require insurance verification prior to billing only for inpatients and for the emergency room and outpatient services, allow verification through submission of the initial claim. Other commenters asked what constitutes verification of insurance coverage.

RESPONSE: The Department believes that insurance verification is cost-effective and practical. It is common business practice to verify insurance coverage prior to providing care to a patient. It is similar to verifying a person's credit card prior to accepting a purchase. In both instances, it only takes a short time to make a phone call for verification and saves the hospital greater time and expense in the future in the case of problems. A phone call to the insurance company or electronic verification would constitute adequate verification. The language in the rule has been revised to clarify this issue.

COMMENT: N.J.A.C. 8:31B-4.41D(f) requires the denial of any claims otherwise eligible for charity care when an insurer deems that their precertification requirements have not been followed. Some commenters remarked that this requirement is unduly harsh and punitive.

RESPONSE: The Charity Care Program is generally the payer of last resort in the hosptal care system in New Jersey. Therefore, it is imperative that all patients be screened by hospitals to determine any and all third party insurance benefits and the potential eligibility for any public assistance programs that might pay towards the hospital bill. This will assure that the Charity Care Program, with its limited funds, will serve only those patients whose bills are truly eligible for charity care assistance. Furthermore, the Department believes that a patient has the responsibility to abide by his or her insurance company's precertification requirements.

COMMENT: One commenter urged that a distinction be made in devising the interviewing and financial screening requirements as they apply to inpatient versus outpatient settings. Significant costs and patient delays may result in applying these requirements to outpatient setting.

RESPONSE: The rules should not make a distinction between inpatients and outpatients in the charity care screening and documentation requirements. Furthermore, as mentioned previously, since the Charity Care Program is generally the payer of last resort in the hospital care system in New Jersey, it is imperative that all patients be screened by hospitals to determine any and all third party insurance benefits and the potential eligibility for any public assistance programs that might pay towards the hospital bills. Only a complete screening of outpatients as well as inpatients will assure that the Charity Care Program, with its limited funds, will serve only those patients whose bills are truly eligible for charity care assistance.

COMMENT: The proposed rule requiring New Jersey residency (N.J.A.C. 8:31B-4.41F(b)) raised numerous comments. Some commenters recommended that the requirement that an applicant be residing in New Jersey for three months prior to the date of service in order to be eligible for charity care be eliminated, since compliance by hospitals is neither feasible nor practical.

Comments suggested that it is too difficult to truly determine a patient's "intent to stay." It was also noted that any attempt to determine "intent to remain in the state appears to be meaningless."

One commenter expressed concern that compliance will add to the administrative costs of the admitting areas. Another mentioned that an identification card, such as a driver's license with only an expiration date and no date of issuance, will not be helpful.

Other commenters stated that this residency section does not address residency documentation requirements for migrant worker or homeless applicants.

RESPONSE: The requirement that an applicant must reside in New Jersey for three months prior to the date of service in order to be eligible for charity care is both feasible and practical. This requirement is consistent with most other assistance programs, including Medicaid, which requires a three month prior residency in New Jersey to qualify for eligibility. In addition, much of the information the hospital routinely obtains through the application process, as described throughout N.J.A.C. 8:31B-4.41D through 4.41K, will include information verifying a person's residency of at least three months, including a utility bill showing a New Jersey residence, a copy of a lease or deed to a residence, or a bank statement. Additionally, more recent driver's licenses have an issue date listed along with the expiration date.

The Department appreciates the difficulty in documenting applicant's intent to stay, but the rule does require this as an appropriate control of the use of limited resources that are publically funded. Further, hospitals have been documenting this since 1989 under the previous rule.

An applicant who adequately documents that he or she is a migrant worker in New Jersey is automatically deemed a New Jersey resident for purposes of charity care. A homeless applicant may provide an attestation stating that he or she is homeless in order to be considered a New Jersey resident.

The Department believes that this requirement will not add to the administrative costs of the admitting department. Since admitting personnel currently have to verify an applicant's New Jersey residency under prior rules and already obtain much of the required information in processing an application, the Department believes complying with this requirement will not cause hospitals to incur any additional costs.

COMMENT: The proposed rule concerning determining family size (N.J.A.C. 8:31B-4.41G) require that "in cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available." Some commenters recommended that a signed attestation from the applicant stating that he or she has been abandoned should suffice. Others asked how this is determined. In addition, there was a request that the Department defer the requirement to document family size until 1994.

RESPONSE: The rules require that financial information from all family members is required because the income standards for charity care vary with family size. If it is unavailable from the noncooperating spouse/parent, an attestation will suffice, providing financial information provided by the cooperating party does not reveal a continuing, interactive economic relationship.

The Department notes that family size had to be documented seriously, and that such documentation should not, therefore, prove to be a burden.

COMMENT: Does immediate medical care provided to non-New Jersey residents apply to inpatient or outpatient or both? Please clarify.

RESPONSE: The rule does not distinguish between immediate medical care for inpatients and outpatients. Immediate medical care provided to non-New Jersey residents applies to both inpatient and outpatient settings. It also refers to off-site hospital locations, as long as the care is provided by the hospital and is part of hospital charges.

COMMENT: It was noted that proposed rule N.J.A.C. 8:31B-4.41H(d)5 requires that the hospital obtain a photocopy of an applicant's welfare ID and document that hospital staff communicated with welfare to verify the current benefit amount. Some commenters suggested that this is not cost-effective and recommended that one or the other of these two requirements should suffice. In addition, hospital attempts to contact the local welfare office can be extremely difficult.

RESPONSE: It is the Department's choice that requiring both a photocopy of an applicant's welfare ID and documentation that hospital staff has communicated with welfare to verify the current benefit amount is important to minimize errors or fraud in the charity care application process. In addition, the Department, in previously recognizing the difficulty a hospital may face in acquiring a written response from the local welfare office, changed this requirement to telephone verification with local welfare. The rule has been revised to clarify this issue. Any further relaxation of this regulatory requirement would jeopardize the screening process for determining a patient's eligibility for welfare assistance.

COMMENT: Other commenters stated that it is unclear how a single paystub can b used as proof of income. Furthermore, documenting length of employment may be problematic.

RESPONSE: The rule (N.J.A.C. 8:31B-4.41H(c)5) states that "An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service, if the paycheck stub indicates a year to date income and if the applicant documents the length of time he or she has been employed by the employer." Length of employment may be obtained through verifying the "year-to-date" on the single paystub, which complies with the requirement.

COMMENT: One commenter questioned whether welfare is to be considered gross income when calculating charity care eligibility for nursing home patients who intend to register with the immigration office, currently receive sole support for the nursing home stay from a welfare agency, and are neither Medicaid or Medicare eligible? This involves emergency admissions wherein aliens not yet registered with the immigration office can qualify for charity care.

RESPONSE: N.J.A.C. 8:31B-4.1H requires hospitals to assure that all applicants document their gross annual income. Welfare benefits must be documented in the determination of income; therefore, the gross benefit must be counted as income. There is no provision in the rules for subtracting expenses from the gross income.

COMMENT: N.J.A.C. 8:31B-4.41I(a)2 requires the hospital to obtain an attestation from a person providing the applicant with support. If a supporter refuses to cooperate, it is argued that a hospital should be allowed to write this account off to charity care.

RESPONSE: N.J.A.C. 8:31B-4.41H(a)2 requires that all applicants must document their income or means of support. The rule does not allow the write-off of an account to charity care unless income or means of support is documented. Allowing write-off without proper documentation would lead to abuse of the charity care system, since patients would no longer be obligated to supply documentation.

COMMENT: The proposed rule at N.J.A.C. 8:31B-4.41L(b) requires a hospital to provide a determination of charity care no later than 10 working days from the date of the request. It is recommended that this be modified to allow 10 working days from the date that the patient's completed application is received.

RESPONSE: The Department has revised the rule to make clear that the 10 day period begins with the submission of a completed application.

COMMENT: If 1990 Census information is used to identify poverty indicators with respect to zip code and hospital service area, what effect will this have on the audit process and reimbursement of charity care subsidies to hospitals?

RESPONSE: These rules are not proposing the use of census data in determining charity care eligibility for purposes of the charity care audit.

COMMENT: One commenter recommended an alternative method of determining patient eligibility for charity care. The idea is to utilize census-driven demographic data to develop income profiles of a hospital's patients. This could be utilized both retrospectively on an institutional basis and prospectively to develop a presumptive eligibility process.

RESPONSE: The Department believes that the 1993 charity care audit required by Chapter 160 should be conducted on the same basis as eligibility was determined in earlier years. This approach will yield the most accurate information for policy analysis and the development of the subsidized insurance program. Therefore, the Department is not changing the rules, but does realize that this proposal has merit as an additional perspective on charity care provision among hospitals.

The Department appreciates any and all ideas on how to improve the system of providing charity care to New Jersey residents in need. The Department, as well as the Essential Health Services Commission and others, are presently considering this idea and others in attempting to improve the system of identifying the charity care patients.

COMMENT: Some commenters suggested that the term "Subsidized Care" be substituted for the current name of "Charity Care."

RESPONSE: The Health Care Reform Act of 1992, P.L. 1992, c.160 uses the term "charity care."

COMMENT: Any patient found eligible under a presumptive eligibility system would still be subject to The Set-Off of Individual Liability (S.O.I.L.) Program or other methods used by the State to increase collections.

RESPONSE: These rules do not propose using presumptive eligibility as a basis for conducting the charity care audit. The proposed rules govern the definition of charity care. They do not address the State's authority to off-set individual's income tax refunds and homestead rebates to satisfy outstanding hospital bills.

COMMENT: The commenter requests that the Department modify the proposed rules to allow the charity care application to be kept in a permanent file separate from the individual patient accounts, and allow the hospital to make the charity care file available for audit.

RESPONSE: The Department will modify N.J.A.C. 8:31B-4.41D(a) to clarify this issue. The hospital may create a charity care file specifically for audit.

COMMENT: The proposed rule at N.J.A.C. 8:31B-4.41D(c) states that "a patient shall not be screened for charity care if the patient declines to be screened for public assistance or if the patient does not receive a denial from the public assistance agency." It is recommended that the hospital's responsibility be limited to referring apparently eligible patients to Medicaid, and that no hospital should be penalized for a patient's failure to complete the Medicaid screening process.

Additionally, a commenter stated that hospitals should not have to determine a patient's eligibility for public assistance programs.

RESPONSE: The rule requires hospitals to screen patients for all potential third party coverage because the Charity Care Program is generally the payer of last resort. The intent of the law is to maximize available reimbursement from other appropriate programs in order to conserve charity care dollars for patients who are not eligible for any other type of assistance. This issue becomes even more important, since the pool of charity care dollars is limited in 1993 and will shrink in subsequent years.

The proposed rule at N.J.A.C. 8:31B-4-41D(c) states that hospitals are responsible for completing an initial screening on patients for eligibility for third party programs, and referring patients who appear to be eligible. Hospitals are not expected to make definitive eligibility determinations.

COMMENT: A commenter recommends that a baby of a HealthStart mother be considered categorically eligible for charity care when the mother's negligence results in failure to obtain Medicaid eligibility for the child.

The Medicaid Program rules should also be modified to include unborn children of HealthStart mothers as presumptively eligible for medical assistance.

RESPONSE: The rules at N.J.A.C. 8:31B-4.41D through 4.41K require that all applicants, including children, be eligible for charity care for the purposes of this audit only if their parents provide adequate documentation.

The Department believes that the charity care program should recognize that parents should have the responsibility to pursue insurance coverage for their children. It was not the policy historically to grant charity care to the child of a commercially insured parent who neglects to add the child to their insurance policy. The Department holds that the same standard should apply to all patients.

The second portion of this comment is not germane to the proposed rules, which do not address Medicaid eligibility.

COMMENT: The commenter states that the requirement to verify patient assets is time consuming and expensive. Further, the commenter disagrees with the proposal to count equity in real estate other than the applicant's primary residence as a liquid asset.

RESPONSE: The definition of assets contained in the proposed rule at N.J.A.C. 8:31B-4.41J includes equity in real estate other than the applicant's primary residence because the Department believes that limited charity care resources should be available to pay for care for those patients who are unable to pay for their care, and not those patients with investments in assets other than a home. Also, this criteria is consistent with that of other similar programs, that is, Medicaid. Moreover, it is consistent with Chapter 160, which requires that the Charity Care eligibility criteria contain a separate and discrete assets criteria. The rule will be revised, however, to refer to "assets" rather than "liquid assets" to make this provision clearer.

COMMENT: Two commenters object to the provision in the proposed rules which specifies steps which the applicant and hospital must complete in order to document that a spouse or parent is uncooperative with the charity care process. They believe that hospitals should not have to bill an uncooperative spouse or parent.

RESPONSE: The rule at N.J.A.C. 8:31B-4.41I(c) states that an uncooperative spouse or parent must be billed before an applicant's requirement to obtain this information may be waived.

A spouse or parent is legally responsible for a patient's bill. The provision's intent is to ensure that patients do make an effort to contact an uncooperative spouse, and to encourage these spouses/parents to acknowledge their responsibility to either pay the bill or seek charity care.

COMMENT: A commenter asked why the rule allows hospitals to request documentation of living expenses from the applicants, and what the information is to be used for.

RESPONSE: The intent of the provision at N.J.A.C. 8:31B-4.41I(c) is to give hospitals access to this information, because it may be useful in several situations. For example, documentation of living expenses is useful for verifying the applicant's income, especially in situations where the applicant is attempting to document unreported income; where the hospital believes the applicants may not be documenting their entire income; and when the applicant and hospitals are negotiating a payment plan.

COMMENT: The commenter stated that the assets eligibility criteria should be adjusted every year to reflect changes in the cost of living.

RESPONSE: In response to past observations that the assets limits for the Charity Care Program were too low, the proposed rule raises these limits substantially in N.J.A.C. 8:31B-4.41J(a). These limits are consistent with those set by other governmental programs, for example, Medicaid. This rule governs the 1993 audit. However, the Department will share this comment with the Essential Health Services Commission, since the Commission will establish the eligibility criteria for 1994.

COMMENT: One commenter noted that the provision which refers to the procedure for referring applicants to the Violent Crimes Compensation Board is vague and may be misunderstood by hospitals. Specifically, the commenter suggested that the language be changed to read as follows "Those costs of the applicant which are not eligible under the charity care program shall be referred to the Violent Crimes Compensation Board." In addition, it was suggested that the hospitals submit a certificate indicating denial or percentage of a patient's eligibility for charity care to expedite the process.

RESPONSE: The Department has revised the text at N.J.A.C. 8:31B-4.41D(h) to reflect the commenter's concerns.

COMMENT: Some commenters believe that the Department of Health does not have the authority to adopt rules or regulations specifying the eligibility criteria for the Charity Care Program. Further, the commenters state that the Department should re-propose these rules to give the proper public notice as required by the Administrative Procedures Act. The Public Advocate adds that the current charity care rules (N.J.A.C. 8:31B-4.37) have not yet been repealed.

RESPONSE: Chapter 160 requires the Essential Health Services Commission to establish charity care income and assets eligibility standards. The Department is proposing these rules because Chapter 160 requires the Department to complete an audit of charity care. For purposes of defining the audit criteria, the Department proposed these rules which includes charity care eligibility standards. Eligibility must be defined in order to conduct the audit. Moreover, the EHSC endorses these rules and the guidelines in their comments.

The Department proposed these rules in accordance with the Administrative Procedures Act, publishing the proposal at 25 N.J.R. 3707(a), in the August 16, 1993 issue of the New Jersey Register.

The current rule (N.J.A.C. 8:31B-4.37) and the proposed rule (N.J.A.C. 8:31B-4.41) have different purposes. The former governed the determination of approved revenue under the rate setting system created by Chapter 83. These rules govern the audit of charity care as required by Chapter 160. The Department intends to propose the repeal of N.J.A.C. 8:31B-4.37 in November, 1993.

COMMENT: Commenters object to the Department intent to start the audit in September, as the rules will not have been finally adopted by that point. They believe that the rules will subject hospitals to being audited retrospectively on new criteria of which they were unaware.

RESPONSE: This proposal does not address the timing of the audit. Chapter 160 requires the Department to audit 1993 charity care; EHSC has requested the Department to provide them with early audit results. In order to complete the hospitals' audits in time to submit the results to the Commission, it was necessary to conduct a one month sample audit in September. Hospitals were aware of the proposed rule since July 8, 1993 when it was approved for initial publication. Further, if hospitals had been following the former charity care regulations, they will meet all of the requirements proposed, which are substantially the same.

COMMENT: A commenter requested that hospitals be given access to State and Federal data bases in order to verify patients' eligiblity for charity care.

RESPONSE: This is not included in the rules because of legal and technological issues that must be further explored. For example, numerous Federal and State laws govern access to data related to eligibility for governmental programs. A provision in Chapter 160 re-

quires the EHSC to conduct research into the development of a system whereby hospitals would have access to such data bases. The Commission may wish to investigate this issue in 1994.

COMMENT: Two commenters expressed concern over the fact that the proposed rules do not contain an appeals process for patients who disagree with the hospital's determination. Commenters requested that the appeals process be reinstated, and inquired as to who will address such appeals.

RESPONSE: These rules set forth the procedure by which the Department will conduct an audit of the hospitals' provision of charity care during 1993. Administrative agencies afford entities to which its rules apply an opportunity to contest the Department of Health's action vis a vis them. Therefore, hospitals will be afforded an opportunity to contest the audit findings if disagreements concerning them cannot be resolved. However, the Department does not control when a hospital can or cannot treat a patient free of charge. Therefore, the Department cannot stand in the stead of either a hospital who determines that a patient does not qualify for charity care or the citizen who claims that he does before an administrative law judge. Charity care subsidies are currently distributed by formula and hospitals set their own rates.

COMMENT: One commenter recommended that the charity care application be made easier for the patient to read.

RESPONSE: Prior to these proposed rules, hospitals were permitted to use charity care applicaitons of their own design; therefore the Department did not regulate the applications. The proposed rule at N.J.A.C. 8:31B-4.41L(a) requires that hospitals use a standardized application. the Department has been working with the Charity Care Policy Committee to design a standardized application form. The Department will convey this comment to this Committee.

COMMENT: The EHSC notes that issues raised by hospitals will also confront the Commission in their efforts to design a subsidized insurance program (SIP). The Commission believes that, in the interest of accountability, hospitals should continue to be required to document compliance with eligibility criteria for each applicant.

Second, the Commission acknowledges the necessity for a prompt 1993 charity care audit process, and requests the Department to conduct a limited sample audit in time to have results available before the end of 1993. Finally, the Commission endorses the Department's proposed charity care eligibility criteria.

RESPONSE: The Department acknowledges the Commission's parallel concerns in developing the SIP, and notes the endorsement of the proposed criteria for charity care. Further, the Department believes that the design of the audit and the proposed time line for completing the audits, will enable the Commission to have access to the results in a timely manner.

COMMENT: One commenter writes that patients should be informed that they will be billed for services until they have provided all documentation for the charity care application.

RESPONSE: This comment is not related to the Department's proposal, which governs the required audit of hospitals' 1993 charity care.

COMMENT: Several commenters argued that preparing the audit list with charity care write-off amounts stated at the Medicaid rate would be extremely difficult, especially for outpatient cases. It was suggested that hospitals be permitted to report charity care write-off amounts at charges and that the Department of Human Services convert changes to the rate that would have been paid by the Medicaid program.

RESPONSE: The Department does not recommend a change to the proposal which requires hospitals to record charity care write-offs at the Medicaid rate, as required in N.J.A.C. 8:31B-4.41A and 4.41B. This requirement will provide for consistency and comparability across all hospitals. Moreover, Chapter 160 provides for payment of charity care at the Medicaid rate. The Department does understand that there may be some start up difficulties until hospitals can fully implement an accounting system. Therefore, hospitals may report charity care write-off amounts at charges for the sample audit of August 1993 charity care only. The Department of Health will be collecting information from hospitals in order to value these accounts at the Medicaid rate.

COMMENT: One commenter stated that the patient responsibility portion of the hospital bill should be based on charges, and not the Medicaid rate.

RESPONSE: The charity care eligibility and patient responsibility percentages are, by definition, complementary, and total 100 percent. While the charity eligibility percentage is applied to the Medicaid rate (less any third party payment) to determine the charity care write-off, Chapter 160 requires that patient responsibility be applied to charges (less any third party payment) to determine the amount that the patient should be billed. The formula, as stated in the proposal at N.J.A.C. 8:31B-4.41B, calculates patient responsibility by subtracting the charity care eligibility percentage from 100 percent. This percentage is then applied to charges (less any third party payment). The Department believes that this formula is mathematically correct and is consistent with the legislation.

COMMENT: Two commenters stated that charges should be reduced by third party payment in the calculation of allowances.

RESPONSE: The Department agrees with this comment and has revised the formula at N.J.A.C. 8:31B-4.41B more accurate and more consistent with the proposal's intent. The revised allowance formula will reduce charges by third party payment.

COMMENT: Some commenters believe that it is not fair to require hospitals to pass all nine compliance steps. It was suggested that each step be weighted and that more flexibility be permitted on outpatient accounts. One commenter suggested that partial credit be given in cases where the charity eligibility percentage is incorrectly determined.

RESPONSE: The Department believes that patients should successfully qualify for charity care based on all of the criteria set forth in the rules. A hospital that systematically waives a specific requirement would undermine the intent of the rules. The adjustment methodology described in N.J.A.C. 8:31B-4.41N does allow for random errors and will not adjust a hospital's charity care total until the fail rate meets or exeeds 10 percent.

COMMENT: One commenter wanted to know if listing adjustments could be positive if the Medicaid reimbursement rate is higher than charges.

RESPONSE: Chapter 160 requires that charity care reimbursement be set at the level that would have been paid by the Medicaid program. The purpose of the listing adjustment is to adjust a hospital's listing total to the Medicaid amount, based on a sample of accounts. Since the Department will be valuing the universe of August 1993 charity care accounts at the Medicaid rate, there will be no need for a listing adjustment. The amount of a hospital's listing total valued at the Medicaid rate will serve as a proxy for 1993 charity care, regardless of whether the total is higher or less than hospital charges.

COMMENT: One commenter questioned the appropriateness of complying with charity care audit criteria for hospitals that are either not currently receiving subsidy dollars or do not wish to receive subsidy dollars in the future.

RESPONSE: Chapter 160, section 9(b)(5), requires that the Department of Health conduct an audit of each hospital's 1993 charity care, regardless of subsidy status.

COMMENT: Two commenters requested additional time to retrieve charity care files for audit.

RESPONSE: The timetable for retrieving files, in N.J.A.C. 8:31B-4.41A, is similar to that used in prior year audits. The schedule was based on the number of files that needed to be reviewed, and did not present timing problems in the past. Further, the 1993 charity care audit planned to date only looks at one month, and not the entire year. This will result in the need to retrieve far fewer files, yet the Department has maintained the same timeframe.

COMMENT: One commenter questioned what information is to be provided on the audit list.

RESPONSE: As in prior years, the list should include patient name, account number, write-off date, and write-off amount. The list should be rank ordered from high to low, based on the write-off amount. The Department has revised N.J.A.C. 8:31B-4.41A(a)1 to include this information.

COMMENT: Some commenters suggested that hospitals should have the right to appeal all audit adjustments.

RESPONSE: Chapter 160 does not create an administrative review process with respect to the charity care audit. The Department has provided for an exit conference review of audit results at which time results are discussed. The Department would also be willing to meet with hospitals to discuss problem areas and to formulate corrective action plans. If this process is not successful, the Department will afford the hospital an administrative hearing and has included such a provision in the rules at N.J.A.C. 8:31B-4.41N(d).

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

8:31B-4.41 Charity care audit functions

The Department of Health will conduct an audit of acute care hospitals' charity care in calendar year 1993 in accordance with N.J.A.C. 8:31B-4.41A through 4.41N.

8:31B-4.41A Sampling methodology

(a) The Department of Health will audit charity care claims based on a sample which will be developed in the following way:

1. Hospitals shall maintain their charity care list in a way that will allow the Department of Health to select accounts for unit dollar sampling. ***The list should include patient name, account number, write-off date, and write-off amount.*** Hospitals shall rank order all charity care accounts from the smallest to the largest, based on the rate that Medicaid would have paid for each account, and run a cumulative dollar balance on the list. Once the selection of sample dollars has been completed and the associated patient accounts have been identified, hospitals will be required to retrieve the patient account files according to the following schedule:

Number of files to be retrieved	Time to retrieve
300-500 files	One week
501-1100 files	Two weeks
1101-1800 files	Three weeks
1801 files and above	Four weeks

(b) The Department of Health will require hospitals to make a small number of additional charity care accounts available upon audit.

8:31B-4.41B Charity care write off amount

(a) Hospitals shall record inpatient and outpatient charity care write-off amounts at the rate paid by the Medicaid program on the date that the service was provided as described in (a)1 below. Inpatient Medicaid rates are determined by grouper assignment applied to the rate per case amounts established by the Medicaid Program. Outpatient Medicaid rates are determined using Medicaid principles for a given outpatient service. In the event that a hospital did not record all charity care write-offs at the Medicaid rate, the hospital must convert such accounts to the Medicaid rate in preparing the charity care list for audit.

1. Charity Care Write Off Amount = (Charity Care Eligibility Percentage, as determined by N.J.A.C. 8:31B-4.41H) × (Medicaid Payment Rate)

2. In the event that there is a partial payment from a third party, the charity care write-off amount is determined as follows:

Charity Care Write Off Amount = (Medicaid Payment Rate – Third Party Payment) × (Charity Care Eligibility Percentage)

3. If the third party payment is greater than the Medicaid payment rate, then the charity care write-off amount shall be listed as 0.

(b) Patients eligible for charity care at 100 percent shall not be billed. Any difference between hospital charges and the Medicaid rate shall be recorded as a contractual allowance.

(c) Patients eligible for charity care at less than 100 percent shall be billed as follows:

Patient Responsibility = (100% – Charity Care Eligibility Percentage) × (Hospital Charges – any third party payment)

[Contractual allowance = (Hospital Charges) – (Charity Care Write Off + Patient Responsibility)]

Contractual allowance + (Hospital Charges – any third party payment) – (Charity Care Write Off + Patient Responsibility)

8:31B-4.41C Posting of notice of availability of charity care

(a) Hospitals shall post notification of the availability of charity care as follows:

1. The Department shall provide to acute-care hospitals notices in English and Spanish about the availability of charity care and reduced charge charity care. Hospitals shall post such notices, provided by the Department, of the availability of charity care in areas of the facility readily accessible and visible to incoming patients, including but not limited to, the admissions area, the business office, outpatient clinic areas, and the emergency room.

2. If the usual language of the households of 10 percent or more of the population in the service area of the facility, according to the most recent figures published by the Bureau of Census, is other than English or Spanish, the facility shall notify the Department, who shall translate the notice into that language and supply the posted notice to the facility. The facility shall then also post the translated notice.

3. The Department shall request the auditors to complete a list of all hospitals which failed to post the charity care notification signs described in (a)1 and 2 above.

(b) Hospitals which failed to post the notification signs will be required to place an advertisement in their local newspaper notifying the public that the hospital will accept applications for patients who received services prior to the date when the signs were placed.

8:31B-4.41D Charity care screening and documentation requirements

(a) The hospital shall correctly assess and document the patient's eligibility for charity care, based upon the criteria set forth in N.J.A.C. 8:31B-4.41A through N. The patient's financial file for audit shall contain the completed charity care application, as well as the supporting documentation which led to the determination of eligibility. ***The hospital may, for purposes of the audit, construct a file containing the information required for the audit to present to the auditors.***

(b) The hospital shall ask the patient if he or she has any third party health insurance. If the patient claims to have insurance, the hospital shall document the name of the insuror and the insured, and all other information pertinent to the insurance coverage. The hospital shall also document that the insurance coverage was verified; or the reason why the coverage could not be verified. ***Verification of insurance may be accomplished by a phone call by hospital staff to the third party insurer.***

(c) If the patient is uninsured, or the patient's health insurance is unlikely to pay the bill in full (based on hospital staff's previous experience with the insurer), and the patient has not paid, at the time of service, any amounts likely to be remaining, the hospital shall make an initial determination for eligibility for any medical assistance programs available. The hospital shall refer the patient to the appropriate medical assistance program and shall advise the medical assistance office of the patient's possible eligibility. The patient's financial file for audit shall indicate either that the patient declined to be screened for medical assistance; that the patient was screened but was determined ineligible; or that the patient was screened and referred to the New Jersey Medicaid medical assistance program for possible eligibility. If the hospital does not screen the patient for medical assistance, the record shall indicate the reason(s) why the patient was not screened and the efforts the hospital made to obtain the screening. A patient shall not be screened for charity care if the patient declines to be screened for medical assistance or if the patient does not receive a denial from the medical assistance agency.

(d) Hospitals shall make arrangements for reimbursement for services from private, and Federal, state and local government third party payers when a person is found to be eligible for such payment. Hospitals shall collect from any party liable to pay all or part of a person's bill, prior to attributing the services to charity care except in the situation described in (h) and (i) below. The hospital shall, as part of this obligation, pursue reimbursement for the uncollected copayments and deductibles of indigent participants in Title XVIII of the Social Security Act (Medicare).

(e) A patient who is categorically and income-eligible for Medicaid but who is determined to be ineligible for failure to provide information or documentation or for other administrative reasons shall not be determined to be eligible for charity care.

(f) A patient who is responsible for complying with his or her insuror's pre-certification requirements (the specific steps with which the insured must comply in order to have the services reimbursed) shall not be determined to be eligible for charity care, if the bill was unpaid because he or she failed to comply with these requirements.

(g) A patient who is determined to be eligible for and accepted into the HealthStart or HealthStart Plus Programs shall not be

deemed eligible for charity care for services which are covered under those programs.

(h) Applicants who are eligible for reimbursement under the Violent Crimes Compensation Program shall be screened for eligibility for the charity care program before referral to the Violent Crimes Compensation Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the *[patient]* ***charges which are not eligible for coverage under charity care*** shall be referred to the Violent Crime Compensation Program. ***The hospital shall request the patient to submit a copy of his or her charity care determination form to the Violent Crimes Compensation Board.***

(i) Applicants who are eligible for reimbursement under the Catastrophic Illness in Children Relief Fund shall be screened for eligibility for the charity care program in accordance with N.J.A.C. 8:18 before referral to this Program. If the applicant is not eligible for 100 percent coverage under the charity care program, then the patient shall be referred to the Catastrophic Illness in Children Relief Fund.

8:31B-4.41E Identification

(a) Applicants for charity care shall provide the hospital with proper identification:

1. Documentation of identification may include, but is not limited to, a driver's license, a voter registration card, an alien registry card, a birth certificate, an employee identification card, a union membership card, an insurance or welfare plan identification card or a Social Security Card. Identification may also be documented by personal recognition by a person not related to the patient.

(b) Hospitals shall obtain a copy of the applicant's identification and produce the copy on audit. The copy of identification may be made in one of two ways: a photocopy of the identification may be made; or hospital staff may copy all pertinent information from the identification source, such as, driver's license number, passport/visa number, and put this information in the patient file for audit. If documentation of identification is provided by personal recognition by a person not related to the patient, the record must include the name, address and phone number of the person who provided the recognition.

(c) Hospitals shall attempt to collect the following information regarding the patient and responsible party (if applicable): name, mailing address, residence telephone number, date of birth, Social Security number, place and type of employment, employment address and telephone number, as applicable.

8:31B-4.41F New Jersey residency

(a) Applicants shall provide the facility with proof of New Jersey residency. Proper proof of New Jersey residency includes the following items: any of the identification listed in N.J.A.C. 8:31B-4.41E which contains the applicant's mailing address, a copy of a deed or lease to a property in New Jersey, an article of mail sent to the patient at a New Jersey address, or a letter from a New Jersey resident with whom the applicant is living stating that the applicant resides with him or her.

(b) An applicant shall provide proof that he or she has been residing in New Jersey for at least three months prior to the date of service, and that he or she has the intent to remain in the State.

(c) Persons who are not New Jersey residents shall not be screened for charity care, unless the care results from an emergency situation requiring immediate medical care. Hospitals shall not report care delivered to non-New Jersey residents as charity care, unless the care is related to an emergency situation requiring immediate medical care. Hospitals shall not report the costs of services delivered to persons who come to New Jersey for the purpose of receiving medical care as charity care.

8:31B-4.41G Documentation of family size

The hospital shall properly determine the applicant's family size in accordance with this section. Family size for an adult applicant includes the applicant, spouse, any minor children whom he or she supports, and adults for whom the applicant is legally responsible. The family size for a minor applicant includes both parents, or a spouse of a parent, minor siblings and any adults in the family for whom the applicant's parent(s) are legally responsible. If an applicant documents that he or she has been abandoned by a spouse or parent, then that spouse or parent is not included as a family member. A pregnant female counts as two family members.

8:31B-4.41H Income eligibility criteria and documentation

(a) The provisions of 42 U.S.C. 990c(2), the poverty income guidelines revised annually by the United States Department of Health and Human Services, are hereby incorporated by reference. (For further information on the poverty income guidelines, contact Gordon Fisher, Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, Washington, D.C. 20201, telephone 202-245-6141). A person is eligible for charity care or reduced charge charity care if he or she falls into one of the following categories:

1. A person whose individual or, if applicable, family income, as determined by reference to (b) below, is less than or equal to 200 percent of the HHS Income Poverty Guidelines shall be eligible for charity care for necessary health services without cost.

2. A person whose individual or, if applicable, family income as determined by reference to (b) below, is greater than 200 percent of the HHS Income Poverty Guidelines but not more than 300 percent of these guidelines is eligible at a reduced rate as described in subsection (b) below.

(b) A person who is eligible for reduced charge health services shall be charged a percentage of the normal charge for health services as follows: the reduced percentage can be applied to the total bill or to any remainder after third party payment.

Income as a Percentage of HHS Income Poverty Guideline	Percentage of Charges Paid by Patient
>200 to 225	20
>225 to 250	40
>250 to 275	60
>275 to 300	80

(c) If the liability (which is unpaid by other parties and billed to the patient) for individuals with incomes between 200 and 300 percent of the Federal poverty guidelines to the patient exceeds 30 percent of the person's, or family's if applicable, annual gross income as calculated by reference to (b) above, this excess will be eligible for 100 percent coverage under the charity care. This 30 percent threshold must be met once per family in a 12 month period.

(d) A person's income, for purposes of determining eligibility for charity care or reduced charge charity care, shall be determined as follows:

1. The applicant may provide proof of the actual gross income for the 12 months immediately preceding the services;

2. The applicant may provide proof of actual gross income for the three months immediately preceding services. The facility will multiply this amount by four to determine the gross annual income; or

3. The applicant may provide proof of actual gross income for the prior month immediately preceding service. The facility will multiply this amount by 12 to determine the gross annual income.

4. If the applicant provides documentation for more than one salary period, the facility shall use the period of time during which the salary was the lowest.

5. If the applicant is a welfare recipient, the facility may document income status by obtaining a photocopy of the applicant's welfare identification, and documenting that the staff of the facility communicated with the local welfare office***, either by telephone or in writing,*** to verify the applicant's current benefit amount.

6. An applicant may request that unreported income be considered in the eligibility determination, as described in N.J.A.C. 8:31B-4.41I(b).

8:31B-4.41I Proof of income

(a) Proof of income shall include Federal or state income tax return, pay check stubs, W-2 forms, a letter from an employer on company letterhead stating the applicant's income, or a statement of the gross benefit amount from any governmental agency providing

benefit to the applicant. An applicant may document his or her income by providing one paycheck stub immediately prior to the date of service if the paycheck stub indicates a year to date income, and if the applicant documents the length of time he or she has been employed by the employer.

1. An applicant may document unreported income, by signing an attestation which states the income obtained in one of the time periods described in N.J.A.C. 8:31B-4.41H(d)1, 2 or 3. The facility may request that the applicant document his or her living expenses for the same time period.

2. An applicant who receives no income or benefits may provide the hospital with an attestation(s) from organizations, or people providing the applicant with support. If the applicant has not received cash assistance, the applicant will be evaluated at $0 gross income.

3. If the applicant is homeless, the facility may accept a signed attestation from the applicant which states that he or she is homeless and receives no support, income or benefits.

(b) Family income that must be considered for the eligibility determination includes the income of all members for whom the applicant is legally responsible including, but not limited to, a spouse and any minor children for an adult. For a minor applicant, the income of the family, as determined by N.J.A.C. 8:31B-4.41H, will be considered. In situations where a minor applicant's parents are divorced, and the custodial parent(s) are remarried, the nonparental spouse's income shall be considered. In situations where both divorced parents have responsibility for the minor applicant's medical care each parent shall complete a charity care application. For a minor applicant the income of the family shall be considered. Only unearned income shall be considered for minor children and siblings. In cases where an adult applicant has been abandoned by a spouse, or a minor applicant has been abandoned by a parent, the applicant may document that a spouse's or parent's income is not available.

(c) If a minor applicant's parents are divorced, and one of the parents is uncooperative, as explained in (c)1 through 3 below, with the application process, then the requirement for that parent's income may be waived after the case is reviewed by the Department of Health.

1. A parent or spouse may be deemed uncooperative if the applicant documents the unsuccesful attempts to obtain the necessary information from the parent or spouse; and

2. The parent or spouse does not respond to a letter from the hospital threatening collection or legal action if he or she does not provide the necessary information for the application; and

3. The parent or spouse does not respond to the hospital's inhouse collection process.

(d) The hospital may request that the applicant document his or her living expenses.

8:31B-4.41J Assets eligibility criteria

(a) An individual is eligible for charity care or reduced charge charity care if:

1. His or her individual *[liquid]* assets as of the date of service do not exceed $3,000; and

2. His or her family's *[liquid]* assets, if applicable, do not exceed $6,000 as of the date of service.

(b) Family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 8:31B-4.41I(b).

(c) *[Liquid assets]* ***Assets, as used in this section,*** are assets which consist of, or which can be readily converted into, cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, IRAs (Individual Retirement Accounts), trust funds, and equity in real estate other than the patient's or family's, if applicable, primary residence. A primary residence, for purposes of charity care, is defined as a residence zoned for a single family in which the applicant currently lives.

(d) Where applicable, the applicant may document his or her or family *[liquid]* assets by presenting the hospital with documentation of the value of any of the assets as of the date of service, or, in the case of a checking or savings account, provide a statement of the average daily balance of the accounts for the month in which he or she received services.

(e) The assets of an applicant for charity care shall be counted only after the applicant has had an opportunity to apply any amount of assets in excess of the limits in (a) above to the hospital charges for which the applicant seeks charity care.

8:31B-4.41K Additional information to be supplied to facility by applicant

A facility shall, as a condition of finding any applicant eligible for charity care or reduced charge charity care, require the applicant to furnish any information that is reasonably necessary to substantiate the applicant's income and assets and that is within the applicant's ability to supply.

8:31B-4.41L Application and determination

(a) The Department of Health shall provide acute care hospitals with a standardized application and determination form. This application and determination form shall be used by all acute care hospitals for the charity care program.

(b) A patient or responsible party may request a facility to make a determination for charity care or reduced charge charity care at any time up to one year from the date of service. A hospital may, at its discretion, accept applications after one year from the date of service. Such a determination shall be made as soon as possible, but no later than 10 working days from *[the day of the request]* ***the day an applicant submits a completed application to the hospital****. If the request does not include sufficient documentation to make such a determination, then the applicant shall be permitted to supply additional documentation. The hospital shall promptly provide the applicant with a written copy of its final determination.

(c) A determination that an applicant is eligible shall indicate:

1. The date on which the eligibility determination was made;

2. The date on which hospital services were requested;

3. The date on which the services were or will be provided to the applicant;

4. That the facility will provide charity care services at no charge or at a specified charge which is less than the allowable charge for the services;

5. The applicant's family size, income and eligibility computation; and

6. The length of time that the hospital will provide charity care based on this determination. A hospital shall not provide charity care on the basis of a determination of eligibility that is more than one year old.

(d) The facility shall provide each applicant who requests charity care and is denied it, in whole or part, with a written and dated statement of the reasons for the denial, including information required in (c) above. In addition, this notice shall state that the applicant may reapply if the applicant believes his or her financial circumstances have changed so as to make him or her eligible for charity care for future services. Where a denial is based on a presumption that the patient is eligible for, but not enrolled in, Medicaid, the information upon which the denial is based must be documented.

8:31B-4.41M Collection procedures and prohibited action

Persons determined to be eligible for charity care shall not receive a bill for services or be subject to collection procedures. Persons determined to be eligible for reduced charge charity care shall not be billed or subject to collection procedures for the portion of the bill that is reduced charge charity care. If the portion of the bill that will be charity care cannot be determined prior to billing because third party payments have not been made, any statements shall indicate that the portion of the bill eligible for reduced charge charity care will be identified at a future date.

8:31B-4.41N Adjustment methodology

(a) For listing adjustment, the charity care write off amount for each account should agree with the reimbursement rate that would have been paid to the hospital by the Medicaid program. To the

extent that charity care write off amounts are overstated, the hospital's listing total will be reduced by the percentage of overstatement found in the sample accounts.

(b) For compliance adjustment, each file reviewed must pass the eight compliance steps in N.J.A.C. 8:31B-4.41D through 4.41M. Failure in any one step would fail the file and associated sample dollars. A failure rate (failed dollars/total dollars sampled) that meets or exceeds 10 percent would require an adjustment to the hospital's charity care listing total based on unit dollar sampling.

(c) The hospital's adjusted charity care listing total will constitute the hospital's audited 1993 charity care amount.

(d) A hospital which disagrees with the Department's listing adjustment may request an administrative hearing, which shall be conducted 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.

(a)

DIVISION OF HEALTH CARE PLANNING, FINANCING AND INFORMATION SERVICES

Certificate of Need: Hospital Policy Manual Hospital Capital Cap and Review Process

Adopted Amendments: N.J.A.C. 8:33A-1.10, 1.16 and 1.29

Proposed: August 16, 1993 at 25 N.J.R. 3710(a).

Adopted: October 19, 1993 by Bruce Siegel, M.D., M.P.H., State Commissioner of Health (with approval of the Health Care Administration Board).

Filed: October 20, 1993 as R.1993 d.570, **with substantive and technical changes** not requiring additional public notice (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:2H-1 et seq., specifically 26:2H-5 and 2H-7.

Effective Date: November 15, 1993.

Expiration Date: November 25, 1997.

Summary of Public Comments and Agency Responses:

One commenter, the New Jersey Hospital Association, provided comments on three sections of the proposed amendments to the Hospital Policy Manual. A second commenter, MEDIQ Consulting Group, provided comments regarding N.J.A.C. 8:33A-1.16(d), as did Jersey Shore Medical Center. These comments are summarized together with Department responses below.

The Department has initiated two minor changes to the proposal in N.J.A.C. 8:33A-1.16(d). One change improves the structure of the second sentence without changing the meaning, by adding "as defined" prior to the Guide to Prospective Financial Information reference. The other change involves a reduction in the number of years required for financial projections. The reduction from five to two years is necessary for conformity with the Certificate of Need rule at N.J.A.C. 8:33-4.10(b)6ii, and the requirements of the Guide to Prospective Financial Information, and decreases the burden on the regulated public without impairing the effectiveness of the rules.

N.J.A.C. 8:33A-1.10(a)

COMMENT: The New Jersey Hospital Association (NJHA) stated that the inclusion of modernization, renovation or construction project criteria in this section is inappropriate given the title of this section of the rule, which is "Bed Need." It was suggested that either a title change was in order ("Project Need" was suggested) or the criteria should be moved to a more appropriate section of the rule.

RESPONSE: The Department agrees that the language suggested by the New Jersey Hospital Association for this section of the rule suitably describes the requirements contained in this section of the rule.

N.J.A.C. 8:33A-1.16(d)

COMMENT: MEDIQ and Jersey Shore Medical Center disagreed with the requirement that firms which complete financial feasibility studies be approved by the New Jersey Health Care Facilities Financing Authority (NJHCFFA). The approved list consists of five accounting firms, all of which are "Big Six" accounting firms. MEDIQ states that the feasibility studies done for a CN review project are significantly different from the studies done for financing for the following reasons:

1. The financial perspective for the two purposes would be different. The study for a CN would focus on the viability of the particular service that is being considered, such as, for example, a psychiatric unit. In contrast, the emphasis in the financing process would be on the whole hospital.

2. Due to the time delay between the CN application and financing, the specific elements of the feasibility study done for a CN would be different than the study done for a financing. Information on financial performance and reimbursement, construction costs and financing terms would need to be updated.

3. Some consulting firms specialize in specific areas (for example, psychiatry, radiology) and would be more qualified than the major accounting firms in assisting a hospital in planning specific programs.

4. The NJHCFFA list includes firms which usually do financing. The Authority has no plans to update the list.

5. A hospital may choose a firm which is not on the list to evaluate the viability of a particular project. This information could be used in a CN application. However, if that firm is not eligible to complete the CN application, the hospital must incur additional costs to complete the study.

RESPONSE: The Department's objective in requiring a firm approved by the NJHCFFA to prepare the feasibility study is to increase the usefulness and credibility of the CN process. The amended CN rules also require a higher level of scrutiny by the consulting firm in preparing the study.

The decisions by the LAB, SHPB and the Department concerning the CN should be based on the best available information on volume, revenue and expenditures. These decisions are based on the need for the project, costs, and financial viability. The information should be consistent with the projections used for obtaining financing at a later time. This is not currently the case. Frequently CN and financing decisions are made based on differing assumptions for revenue and costs. The timing of the two feasibility studies only partially determines these differences. The requirement to use an approved accounting firm involves a restriction. However, the Department believes that the restriction is justified based on the improved credibility of the CN process.

Responses to the specific comments are as follows:

1. The Department does not believe that there should be major differences between the feasibility studies done for the CN regarding the financing, other than the differences due to the timing of these studies. The basis of both projections are expenses, volume, and reimbursement. These numbers should be developed based on the same assumptions. Revenue/expense projections for the specific service and the entire hospital are not independent.

2. The Department agrees that the information needs to be updated between the CN application and the financing determination. However, the study done for the financing process should be an extension of the earlier study.

3. The hospital is free to consult with a specialized firm in evaluating whether to develop a specific service. This information could be used for the feasibility studies done for the CN and financing processes. It should be noted that the restriction in consulting firms applies only for projects which exceed $15 million.

4. The NJHCFFA has periodically reviewed its approved list. While there are no current plans to review the list, the qualifications, experience and resources of firms providing these services are reviewed upon direction of the NJHCFFA Board.

5. The feasibility study done for NJHCFFA must be done by an approved firm. Therefore, use of an approved firm for the study required for the CN process will simplify this later process; the CN study could be updated for the feasibility process and reduce the costs for this study.

N.J.A.C. 8:33A-1.29(b)1i

COMMENT: The NJHA stated its support for the use of "adjusted" occupancy rate in this section of the rule.

RESPONSE: The Department agrees that this method of examining an applicant's occupancy can be a useful indicator in determining the priority ranking for projects that have documented compliance with all other sections of the rule.

N.J.A.C. 8:33A-1.29(b)2ii

COMMENT: The NJHA stated that the average age of physical plant criteria was a deceptive indicator of age, and that this criteria should

not be used. "Hospitals with an average age of plant under 10 years may still have extremely old and obsolete facilities."

RESPONSE: The Department does not believe that the use of this criterion, which will only be one of several measures to determine priority consideration of competitive applicants, will impede any applicant that is able to document the need to replace antiquated and obsolete equipment or facilities. The 10 year standard is approximately 20 percent above the statewide average age and represents a clearly defined indicator of relative age. A hospital will still be able to achieve the priority ranking associated with this "project need" section of the rule, regardless of its average age of physical plant, if it can demonstrate that the physical plant condition being corrected "is substantially correcting life safety code deficiencies or other conditions that pose imminent peril to the health and safety of patients and staff" (at N.J.A.C. 8:33A-1.29(b)2i). There are also other prioritization criteria that could be met by such an applicant, in the event that neither of the sections dealing with "project need" could be met by a given applicant. It is therefore the Department's view that the average age criterion represents an appropriate standardized indicator of relative physical plant condition and is an appropriate criterion for its intended use in this section of the rule.

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

8:33A-1.10 *[Bed]* ***Project*** need

(a) Any application for establishment of or expansion of licensed beds must demonstrate need for these beds in the proposed service area based upon needs assessment methodologies represented in the most recent acute care bed need estimates developed and promulgated by the Department. All applicants, prior to submission, should consult with their respective LABs regarding their plans to assure that the projects address community needs, project needs, project goals, cost issues and revenue stability criteria (to the extent that this information is available) and will be competitive in accordance with the review process for the hospital capital cap at N.J.A.C. 8:33A-1.29.

(b) (No change.)

8:33A-1.16 Standards regarding equity contributions and financing

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

(d) All applicants shall demonstrate the financial feasibility of their projects. An appropriate financial feasibility study shall be submitted for projects in excess of $15 million at the time of application. The financial feasibility study shall be prepared by an accounting firm approved by the New Jersey Health Care Facility Financing Authority for such studies, and shall express an opinion based on an examination of projections ***as defined*** in the American Institute of Certified Public Accountants' Guide to Prospective Financial Information. A project will be determined financially feasible where the applicant can demonstrate a net positive income beginning in the calendar or fiscal year which is two years beyond project completion. Financial projections shall be provided for the first *[five]* ***two*** full years after project completion. These projections shall indicate the method of funding any losses incurred during this time period.

(e) All projects will be evaluated based on relative cost considerations in comparison to Statewide norms including capital expense per adjusted admission, and total operating expense per adjusted admission.

8:33A-1.29 Hospital capital cap and review process

(a) (No change.)

(b) Having met all other applicable criteria in this chapter and N.J.A.C. 8:33, for the 1993 and 1994 hospital acute care calls only, projects shall be prioritized according to the criteria below. Those projects meeting the greater number of criteria shall receive priority consideration for approval. Approval of certificates of need as limited by the Statewide cap of $225,000,000 will be determined based on the prioritization criteria.

1. Community need: A hospital will be deemed to have exhibited priority community need when it has the following characteristics:

i. Occupancy in excess of optimal occupancy rates (as specified in N.J.A.C. 8:33A-1.11(a)) in all services proposed for expansion, and adjusted occupancy rates in excess of minimum rates by at least 10 percent in all other bed categories during the last 18 months preceding the application. Adjusted occupancy, for each bed category not being expanded, shall be calculated as follows:

(1) Adjusted bed-day capacity = Licensed beds in a category minus changes in beds in the category multiplied by the total days in the 18 month period (547 days);

(2) Adjusted occupancy = Actual patient days in the categories in the prior 18 month period (547 days) divided by the adjusted bed-day capacity for that category; and

ii. The county's and hospital's rates of inpatient admission and length of stay have been demonstrated to be appropriate and not likely to decline as a result of changing medical practice or reimbursement policy. Appropriateness of a hospital's average length of stay (ALOS) shall be determined by comparison, in each licensed bed category, to the Statewide average ALOS for that category. A hospital ALOS, in any bed category, in excess of the Statewide ALOS for that category by more than 20 percent shall be considered inappropriate. A hospital whose ALOS, in any bed category, has been deemed inappropriate in the above manner shall provide justification to the Department. The Department will evaluate such justifications and make a determination of appropriateness of the ALOS, based upon the data provided by the hospital, as well as data maintained by the Department. If the Department determines that a hospital's ALOS is appropriate, even though it exceeds the Statewide ALOS plus 20 percent, an exception to this criterion may be made.

2. Project need:

i. The project is substantially directed to correcting Life Safety Code deficiencies, or other conditions that pose imminent peril to the health and safety of patients and staff; or

ii. The overall average age of the physical plant exceeds 10 years based on the Department's calculations using generally accepted accounting principles; and

3. Project goals:

i. The certificate of need application has been submitted in order to address a public health priority or a specific recommendation set forth in Department health planning guidelines, and is determined by the Department to be essential to achieving that goal. Specifically, these may include hospital closure or merger applications that demonstrate significant cost savings to the health care system, projects which significantly and demonstrably improve access for populations which have been shown historically to lack access to hospital services, or projects implementing ambulatory care initiatives that improve health care delivery patterns and reduce system expenditures; and

ii. The facility historically has served a greater than average proportion of medically underserved populations in comparison to the percent of the population in its community; meets Federal and State obligations for providing uncompensated care, community services, access by minorities (race, ethnic, others) and special needs populations (for example, AIDS); offers a range of means by which persons will have access and availability to its services (for example, outpatient services, admission by house staff, admission by personal physician); is accessible by public or private transportation; as applicable, assures effective communication between the staff of the proposed project and non-English speaking people and those with speech, hearing, or visual handicaps; and to the extent possible, eliminates architectural barriers to care for handicapped individuals and/or describes other unique circumstances.

(c) The strength of the demonstration and the number of prioritization factors demonstrated will be considered in the ranking of projects. The projects will also be evaluated based on relative cost considerations including total operating expense per adjusted admission and capital expense per adjusted admission in comparison to Statewide medians.

(a)

DIVISION OF HEALTH FACILITIES EVALUATION AND LICENSING
OFFICE OF EMERGENCY MEDICAL SERVICES
Manual of Standards for Licensure of Invalid Coach and Ambulance Services
Adopted Amendments: N.J.A.C. 8:40-1.1, 2.3, 2.7, 2.12, 3.1, 4.12, 4.13, 5.23 and 6.26

Proposed: June 21, 1993 at 25 N.J.R. 2663(a).
Adopted: October 19, 1993 by Bruce Siegel, M.D., M.P.H., Commissioner of Health (with the approval of the Health Care Administration Board).
Filed: October 21, 1993 as R.1993 d.594, **with 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-6.3 and 6.4
Effective Date: November 15, 1993.
Expiration Date: December 6, 1996.

Summary of Public Comments and Agency Responses:

One comment was received, as listed below:

COMMENT: Mr. Paul Roman of Shrewsbury, New Jersey commented, supporting the proposed changes and encouraging the Department to extend the recognition of EMT-As from other recognized certification agencies to other programs (for example, EMT-D and paramedic training programs.

RESPONSE: The Department acknowledges the supportive comment. With regard to the extension of the recognition of EMT-As in other areas, the Department is constrained by Statutes and by other rules from extending this recognition at this time. (See N.J.S.A. 26:2K-7 et seq. and N.J.A.C. 8:41 and 8:41A.) The Department will continue to monitor this area.

Summary of Agency-Initiated Changes:

At N.J.A.C. 8:40-2.12, the address of the Office of Emergency Medical Services is changed to reflect the correct address, as the Office has moved since the last adoption.

At N.J.A.C. 8:40-4.12(b), the phrase "shall possess valid certification on an Emergency Medical Technician-Ambulance" is corrected to read "shall possess valid certification as an Emergency Medical Technician-Ambulance."

At N.J.A.C. 8:40-4.13(a)2, the reference to the administrative code is incorrect. The reference is corrected to read "N.J.A.C. 8:40-4.3(f)", which represents the correct codification for that passage.

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

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.

...

"Emergency medical technician-ambulance (EMT-A)" means an individual trained and currently certified or recognized 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 Traffic 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.

...

"Street EMS" means the provision of primary emergency care at the basic life support level, to a municipality or municipalities in accordance with the intent of N.J.S.A. 27:5F-18 et seq.

...

8:40-2.3 Special requirements for licensees providing street EMS

(a) Licensed services and municipalities providing emergency ambulance services ("street EMS") cannot discontinue services without sending written notification to the Department at least 60 days prior to the planned closure date.

(b) No licensee providing "street EMS" shall fail to respond to an emergency call or refuse to provide emergency treatment and transportation to any person because of that person's race, sex, creed, national origin, sexual preference, age, disability, medical condition, or ability to pay.

8:40-2.7 Application for licensure and/or vehicle licenses

(a) 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 367
Trenton, NJ 08625-0367

(b)-(d) (No change.)

(e) Each set of application(s) submitted to the Department shall be accompanied by a single check in the correct amount made payable to "New Jersey Department of Health."

(f)-(h) (No change.)

(i) Should an applicant submit an incomplete application, no license shall be issued. Incomplete applications shall be returned to the applicant with no action taken, pending proper completion.

(j) No application will be processed from an applicant if the proposed trade name of the company duplicates or is essentially similar to a currently licensed company's trade name, or to the trade name of a company which has an application pending before the Department.

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]* ***367***
Trenton, NJ 08625-*[0364]****0367***

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 at the time of application. All owners (100 percent of the company's ownership) shall be listed, indicating the owners' percent of ownership and home address. Proof of this ownership shall be made available to representatives of the Department.

(b) Any corporation which proposes a redistribution of 10 percent or more of its stock, changes its trade name, or any individual owner, partnership or proprietorship which proposes any redistribution of stock whatsoever, must submit a new application for licensure and receive new provider and vehicle permits or licenses before starting to provide service with the new name and/or owners. Any licensed agency which proposes a change in the scope of its service must contact the Department to ascertain if new provider and vehicle permits will be needed before changing the type of service it provides.

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

(e) The past licensure track record performance of any companies licensed under this chapter will be considered when the principals or owners of those companies apply for licensure of any new company, or change in scope of service. The Department may refuse to issue any license until the Department is assured that:

1. The applicant demonstrates continued compliance with all applicable laws, rules and regulations; and

2. The issuance of the license will not pose a threat to the general public health and safety.

(f) (No change in text.)

8:40-4.12 Required training of staff

(a) (No change.)

(b) If oxygen administration devices are carried in the vehicle, the required staff person(s) shall possess valid certification *[on]* ***as*** an Emergency Medical Technician-Ambulance, issued or recognized 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. (No change.)

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]* ***4.3(f)****;

3.-6. (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 or recognized by the Department.

(b) (No change.)

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 or recognized by the Department.

(b) (No change in text.)

(a)

PUBLIC HEALTH COUNCIL

Readoption with Amendments: N.J.A.C. 8:44

Proposed: September 7, 1993 at 25 N.J.R. 3905.

Adopted: October 21, 1993 by the Public Health Council, William A. Frascella, Jr., O.D., chairman.

Filed: October 21, 1993 as R.1993 d.595, **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. 26:14-7 and 45:9-42.26 et seq., specifically 45:9-42.34.

Effective Date: October 21, 1993, Readoption;
November 15, 1993, Amendment.

Expiration Date: April 20, 1995.

Summary of Hearing Officer's Recommendations and Agency Response:

A public hearing was held on September 13, 1993 in the Health-Agriculture Building at 2:00 P.M., chaired by Dr. William Frascella. No one appeared to testify at the hearing. The hearing record may be reviewed by contacting Susan Eates, Department of Health, CN 360, Trenton, NJ 08625.

Summary of Public Comments and Agency Responses:

COMMENT: Abbott Laboratories commented that the readopted rules are inconsistent with the language of a statutory amendment to the New Jersey Clinical Laboratory Improvement Act (N.J.S.A. 45:9-42.26 et seq.) which became effective February 19, 1991 and is codified in N.J.S.A. 45:9-42.33. That amendment sets forth exceptions to the clinical laboratory requirements for State and county corrections facilities, and drug/alcohol rehabilitation facilities providing services to any person under jurisdiction of such facilities, such as drug/alcohol urinalysis rules.

RESPONSE: This statutory amendment will be incorporated into these rules as an amendment with this readoption. While it does constitute a significant change, no republication or public hearing will be required for this amendment since it duplicates, exactly, the text of the statute at N.J.S.A. 45:9-42.33d.

COMMENT: The New Jersey Society of Pathologists recommended that in the review and revision of these rules scheduled to occur over the next 18 months, modifications should be made to bring the rules into compliance with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) and proposed a number of specific areas of the present rules that should be closely scrutinized.

RESPONSE: It is anticipated that CLIA '88 will have a significant impact on the revised rules. The rules may not exactly mirror the Federal rules, but will comply with the statutory requirement that State regulations equal or exceed minimum Federal standards. The recommended areas as well as all sections of the existing State rules will be carefully examined in the revision process.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 8:44.

Full text of the adopted amendment follows (additions to proposal indicated in boldface with asterisks ***thus****; deletions from proposal indicated in brackets with asterisks *[thus]*):

8:44-2.2 Applicability of regulations

(a) (No change.)

(b) The *[regulations]* ***rules*** do not apply to the following:

1.-3. (No change.)

4. Blood banks licensed under P.L. 1963, c.33 (N.J.S.A. 26:2A-2 et seq.); *[and]*

5. Clinical laboratories possessing a Federal Certificate of Waiver as defined by Federal Clinical Laboratory Amendments of 1988 (CLIA '88) (P.L. 100-578) and regulations adopted thereunder (42 CFR Part 493, published in the Federal Register, February 28, 1992)***; and***

6. Clinical laboratories which are operated by the Department of Corrections, any county jail, any county probation department, or any drug or alcohol treatment center providing services to persons under the jurisdiction of any of these agencies or in a program of supervisory treatment pursuant to the provisions of N.J.S. 2C:43-13 and which perform only urinalysis for screening purposes to detect the presence of alcohol or illegal substances. The Attorney General shall approve procedures, methods and devices used by these agencies or centers in screening for alcohol or illegal substances*.

(b)

DIVISION OF EPIDEMIOLOGY, ENVIRONMENTAL AND OCCUPATIONAL HEALTH SERVICES

Reporting of Occupational and Environmental Diseases and Injuries by Physicians

Adopted Amendment: N.J.A.C. 8:57-3.2

Proposed: June 7, 1993 at 25 N.J.R. 2186(a).

Adopted: October 18, 1993 by the Public Health Council, William Frascella, Jr., O.D., Chairperson.

Filed: October 20, 1993 as R.1993 d.569, **with a substantive change** not requiring additional public notice and comment (See N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 26:1A-7.

Effective Date: November 15, 1993.

Expiration Date: April 20, 1995.

Summary of Hearing Officer's Report:

Dr. William Frascella chaired a hearing in the Health-Agriculture Building on Monday, June 14, 1993 at 2:00 P.M. No one attended to testify.

Summary of Public Comments and Agency Responses:

No comments received.

Summary of Agency-Initiated Changes:

Under reporting of cadmium toxicity in paragraph (b)9, the words "of whole blood" are inserted after "liter." This is to clarify the clinical definition for the reporting requirement and to have wording that is consistent with requirements by the Federal Occupational Safety and Health Administration for biological monitoring for cadmium exposure. This change does not alter the meaning or significance of the original text.

Full text of the adoption follows (additions to proposal indicated in boldface with asterisk ***thus***):

8:57-3.2 Reporting of occupational and environmental diseases and injuries by physicians:

(a) The physician attending any person who is ill or diagnosed with any of the diseases or injuries listed in (b) below shall, within 30 days after such condition has been diagnosed or treated, report such condition to the State Department of Health.

(b) The following diseases and injuries are declared to be reportable to the State Department of Health for purposes of this section. All conditions listed herein are to be reported in the manner prescribed by (c) below:

1.-4. (No change.)

5. Extrinsic Allergic Alveolitis;

6. Lead toxicity, adult (defined as blood lead ≥ 25 micrograms per deciliter; urine lead ≥ 80 micrograms per liter);

7. Arsenic toxicity, adult (defined as blood arsenic ≥ .07 micrograms per milliliter; urine arsenic ≥ 100 micrograms per liter;

8. Mercury toxicity, adult (defined as blood mercury ≥ 2.8 micrograms per deciliter; urine mercury ≥ 20 micrograms per liter);

9. Cadmium toxicity, adult (defined as blood cadmium ≥ five micrograms per liter ***of whole blood***; urine cadmium ≥ three micrograms per gram creatinine);

10. Pesticide toxicity;

11. Work-related injuries in children (under age 18); and

12. Work-related fatal injuries.

(c) The report required by (a) above shall state the name of the disease or injury and the name of the reporting physician. The following information on the person ill or diagnosed with such condition shall also be furnished: name, year of birth, sex, home address, telephone number, name and address of employer at the time of exposure or injury, and the date of onset of illness or injury. Additional information may be required by the Department after receipt of a specific report.

HUMAN SERVICES

(a)

CONTRACT POLICY AND MANAGEMENT UNIT

Contract Administration

Readoption with Amendments: N.J.A.C. 10:3

Proposed: August 16, 1993 at 25 N.J.R. 3694(b).

Adopted: October 21, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: October 22, 1993 as R.1993 d.597, **without change.**

Authority: N.J.S.A. 30:1-12.

Effective Date: October 22, 1993, Readoption;
November 15, 1993, Amendments.

Expiration Date: October 22, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:3.

Full text of the adopted amendments follows:

10:3-1.2 Causes for debarment of a person

(a) Subject to the conditions hereinafter described, the Commissioner may debar a person for any of the following causes.

1. through 12. (No change.)

10:3-1.3 Conditions affecting debarment of a person(s)

(a)-(e) (No change.)

(f) Debarment for the cause set forth in N.J.A.C. 10:3-1.2(a)12 shall be proper provided that one of the causes set forth in N.J.A.C. 10:3-1.2(a)1 through 11 was the basis for debarment by the original debarring agency. Such debarment may be based entirely on the record of facts obtained by the original debarring agency, or upon a combination of such facts and additional facts.

10:3-2.2 Capital Funding Agreement for Construction, Purchase or Purchase and Renovation of Community-Based Facilities

(a) The Department efforts to consolidate division-specific contracts/agreements has culminated in the development of a Standard Contract/Agreement Document for the Construction, Purchase, or Purchase and Renovation of Community-Based Facilities. Copies of the Standard Document and updates may be obtained from:

Facilities Support Services
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or Facilities Support Services, CN 700, 222 South Warren Street, Trenton. This document will not be reproduced in the New Jersey Administrative Code.

10:3-2.3 Capital Funding Agreement for Renovation, Remodeling, Extension or Other Improvements to Agency-Owned or Leased Community Facilities

(a) The Department efforts to consolidate division-specific contracts/agreements has culminated in the development of a Standard Contract/Agreement Document for the Renovation, Remodeling, Extension or Other Improvements to Agency-Owned or Leased Community Facilities. Copies of the Standard Document and updates may be obtained from:

Facilities Support Services
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or Facilities Support Services, CN 700, 222 South Warren Street, Trenton. This document will not be reproduced in the New Jersey Administrative Code.

10:3-2.4 Capital Funding Agreement for Community-Based Facility Planning and Design Services

(a) The Department, continuing in its efforts to consolidate contracts and agreements, has developed the Funding Agreement for Community-Based Facility Planning and Design Services document to be used by all divisions for preliminary planning/design services. Copies of the standard document and updates may be obtained from:

Facilities Support Services
Department of Human Services
CN 700
Trenton, New Jersey 08625

(b) (No change.)

OFFICE OF ADMINISTRATIVE LAW NOTE: A copy of the Standard Contract/Agreement Document in (a) above was submitted as part of this proposal but is not reproduced herein. This document may be reviewed at the Office of Administrative Law, 9 Quakerbridge Plaza, Trenton, New Jersey 08625 or Facilities Support Services, CN 700, 222 South Warren Street, Trenton. This document will not be reproduced in the New Jersey Administrative Code.

10:3-3.1 Purpose and scope

This rule applies to all departmental components, County Human Services Advisory Councils (CHSACs) and designated entities when departmental components choose to issue an RFP, and to all groups or entities responding to RFPs for contracts for the provision of third-party social services or training. The RFP process, except when the Departmental component chooses to RFP, shall not be required

for renewal or expansion of Department purchase of service contracts for programs in effect as of November 4, 1991. In addition, the RFP process shall not apply to renewal of contracts for which an RFP was utilized in selection of the current grant recipients.

10:3-3.2 Definitions

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

. . .

"Designated entity" means that group or county board which has been given the authority by the Department of Human Services to solicit human service proposals for review and comment and recommended acceptance for third-party social service Contracts. Although the RFP is handled by a group other than the departmental component, the contract is signed and finalized by the departmental component.

10:3-3.3 Request for proposal

(a) The departmental component or CHSAC/designated entity shall issue a public announcement of the availability of funds for the purchase of services in accordance with N.J.S.A. 52:14-34.4, 34.5 and 34.6. The announcement shall be made in a manner to permit reasonable competition among eligible provider agencies. The departmental component shall publish the announcement in the New Jersey Register. In addition, the announcement may be mailed to identified prospective provider agencies and/or advertised in at least three newspapers of general circulation.

(b) The departmental components may choose to have bidders conferences. Technical information regarding the RFP may be disseminated at such a meeting.

(c) The CHSACs/designated entities, at minimum, shall use the standards set forth in this subchapter when they are delegated the responsibility to solicit proposals on behalf of the Department. In all other instances, the departmental component shall notify the CHSACs/designated entity of the RFP, if appropriate.

(d) (No change in text.)

(e) The departmental component or the CHSAC/designated entity shall forward a proposal package to or it may be picked up by those prospective applicants responding to the public announcement. In addition, when the CHSACs/designated entities have been delegated the responsibility to solicit proposals on behalf of the Department, all appropriate Department procedures, as set forth in this subchapter, and county procedures, as appropriate, must be followed. The proposal package shall contain, at minimum, the following information and requirements:

1.-13. (No change.)

14. A statement explaining the appeals process and that appeals to the departmental component must be completed within the time frame specified in the RFP or within 15 days after receipt of the CHSAC/designated entity recommendation, and that appeals to the CHSAC/designated entity must be completed within the 90 day process time period and prior to the recommendations being sent to the departmental component.

10:3-3.4 Sole source services

Where there is none or only one response to the RFP, after specifications of the RFP have been cited and all criteria of this subchapter have been met, documentation of any and all efforts to obtain multiple responses shall be kept in the Department RFP file. Documentation shall also be retained of every contact made by the departmental component or CHSAC/designated entity to find a provider agency to fulfill the required services.

10:3-3.5 Internal controls for proposals

(a) The departmental component or CHSAC/designated entity shall record all correspondence to and from the departmental component or CHSAC/designated entity, whichever applicable, in a log retained in the individual program RFP file.

(b) Correspondence shall be recorded in the log by a staff person different from the staff personnel who are on the review panel and participating in the selection process.

(c) The log shall indicate, at a minimum, the following information:

1.-5. (No change.)

6. The name of the Department or CHSAC/designated entity staff person receiving the proposal for review and selection;

7.-8. (No change.)

(f) (No change.)

(g) When a CHSAC/designated entity is handling the RFP process, all documentation shall be forwarded to the departmental component responsible for signing the contract for final approval and retention.

(h) The departmental component shall communicate to the CHSAC/designated entity the outcome of any departmental component appeal on a CHSAC/designated entity RFP and forward a copy of the final award letter.

10:3-3.6 Funding proposal program summary and evaluation data; list of required information

(a) The funding proposal requirements shall apply to all proposals submitted to a departmental component or CHSAC/designated entity. Each proposal submitted to a departmental component or CHSAC/designated entity shall contain the following:

1.-25. (No change.)

10:3-3.7 Composition of review panel

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

(c) The panel may consist of an allocations review panel under the CHSAC/designated entity or the following:

1.-11. (No change.)

(d) (No change.)

10:3-3.9 Evaluation of applicant

(a) The applicant shall be evaluated to determine the following (an on-site evaluation may be conducted by the departmental component or CHSAC/designated entity if deemed necessary). The CHSAC/designated entity shall evaluate the applicant on only those factors with which they are familiar or about which they have accurate information. The Department is responsible for evaluation of all information presented by the applicant in the RFP.

1.-9. (No change.)

10:3-3.10 Notification of decision

(a) (No change.)

(b) An appeal based on the determination may be filed according to the procedures established by the departmental component or CHSAC/designated entity which shall be referenced in the notice of decision to the applicant.

(c) (No change.)

10:3-3.11 Document retention

Awarded contracts, signed originals, all support materials and the record copy shall be retained by the departmental component for three years after the termination of the contract and four years thereafter at the records center prior to destruction. Unsuccessful proposals shall be retained for one year by the departmental component and then may be destroyed. The material to be retained includes the RFP, the applicant proposals, all evaluation sheets, and any other documentation which details why the agency was selected or not selected.

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Home Care Services Manual; Definitions

Adopted Amendments: N.J.A.C. 10:60-1.2 (Partial)

Proposed: July 6, 1993 at 25 N.J.R. 2803(a).
Adopted by: William Waldman, Commissioner, Department of Human Services.
Filed: October 21, 1993 as R.1993 d.588, **with a technical change and with portions not adopted but still pending.**

Authority: N.J.S.A. 30:4D-6b(2), 7, 7a, b and c; 30:4D-12; 30:4E; 42 CFR 440.70, 170(f) and Section 1902(w) of the Social Security Act, 42 U.S.C. 1396a.

Effective Date: November 5, 1993.
Expiration Date: February 19, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

The Division of Medical Assistance and Health Services is adopting a portion of N.J.A.C. 10:60-1.2 pertaining to the following definitions: homemaker agency, private duty nursing and private duty nursing agency. The remainder of the proposed amendments remain pending agency review prior to adoption.

The Home Care Manual as proposed on July 6, 1993 remains pending agency review prior to adoption. However, the Department is proceeding to immediately adopt two definitional changes. The first is the expansion of the definition of "homemaker agency" to allow recognition of an agency accredited by the Community Health Accreditation Program (CHAP). This adoption is necessary in order to act upon pending provider enrollment applications. The second is the expansion of the definition of "private duty nursing" and "private duty nursing agency" in order to clearly specify that children eligible under the Early and Periodic Screening Diagnosis and Treatment program are eligible to receive this service.

Summary of Changes Between Proposal and Adoption:
The word "and" has been added to the full name of EPSDT, to clarify that the process involves both early and periodic screening.

Full text of the adopted portions of N.J.A.C. 10:60-1.2 follows (addition to proposal shown in boldface with asterisks ***thus***):

10:60-1.2
The following words and terms when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

...

"Homemaker agency" means a proprietary or voluntary non-profit agency approved by the Department of Human Services, Division of Medical Assistance and Health Services to provide Personal Care Assistant Services, and homemaker services under the Community Care Program for the Elderly and Disabled (CCEPD) and the Home Care Expansion Program (HCEP), and accredited, initially and on an on-going basis, by the Commission on Accreditation for Home Care Inc., the National HomeCaring Council, a Division of the Foundation for Hospice and Homecare or the Community Health Accreditation Program (CHAP).

...

"Private duty nursing" means individual and continuous nursing care, as different from part-time or intermittent care, provided by licensed nurses in the home to recipients under Model Waiver III and the AIDS Community Care Alternatives Program, as well as eligible Early ***and*** Periodic Screening Diagnosis and Treatment (EPSDT) recipients.

"Private duty nursing agency" means a licensed home health agency, voluntary non-profit homemaker agency, private employment agency and temporary-help service agency approved by the Division to provide private duty nursing services under Model Waiver III, and the AIDS Community Care Alternatives Program (ACCAP) and EPSDT. The private duty nursing agency shall be located/have an office in New Jersey and shall have been in operation and actively engaged in home health care services in New Jersey for a period of not less than one year prior to application.

...

(b)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Lifeline Credit Program/Tenants' Lifeline Assistance Program

Readoption with Amendments: N.J.A.C. 10:69B

Proposed: August 16, 1993 at 25 N.J.R. 3701(a).
Adopted: October 21, 1993 by William Waldman, Commissioner, Department of Human Services.
Filed: October 21, 1993 as R.1993 d.586, **without change.**

Authority: N.J.S.A. 48:2-29.1.5 et seq. and 48:2-29.31 et seq.

Effective Date: October 21, 1993, Readoption;
November 15, 1993, Amendments.
Expiration Date: October 21, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 10:69B.

Full text of the adopted amendments follows:

10:69B-1.3 Definitions
The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

...

"Electric utility" means every New Jersey public utility which provides residential electric service, as defined in this section, and is regulated by and subject to the jurisdiction of the Board of Regulatory Commissioners. Additionally, any municipality or other governmental entity providing residential electric service, as defined in this section, within the State of New Jersey, shall be deemed an electric utility for the limited purposes of this program.

"Gas utility" means every New Jersey public utility which provides residential gas service, as defined in this section, and is regulated by and subject to the jurisdiction of the Board of Regulatory Commissioners. Additionally, any municipality or other governmental entity providing residential gas service, as defined in this section, within the State of New Jersey, shall be deemed a gas utility for the limited purposes of this program.

...

10:69B-1.4 Lifeline Credit/Tenant's Lifeline Assistance payment
(a) The Lifeline Credit shall consist of a single amount established by law, which will be applied, on a yearly basis, to the electric and/or gas utility bills of an eligible residential customer. Only one credit per year is allowed per household, regardless of the number of eligible residential utility customers living in that household.

1.-2. (No change.)

3. When an eligible residential utility customer terminates service, the unused balance of the Lifeline Credit shall be dispersed accordingly.

i.-iii. (No change.)

iv. The electric and/or gas utility shall return within 60 days of termination of service, any unused balance that cannot be transferred as stated in N.J.A.C. 10:69B-1.4(a)3i, ii, iii, to the Treasurer, State of New Jersey.

(b) (No change.)

(c) A Special Utility Supplement has been established to assist Supplemental Security Income (SSI) beneficiaries who are not eligible for Lifeline Credit or Tenants Lifeline Assistance. This yearly

supplement amount, established by law in lieu of Lifeline Credit or Tenants Lifeline Assistance, will be added to each monthly SSI check in an amount equal to 1/12 of the yearly supplement.

1. When an SSI beneficiary is no longer eligible for the SSI Program, any remaining balance of the Special Utility Supplement shall be dispersed accordingly.

i. (No change.)

ii. If the terminated SSI beneficiary is not eligible for Lifeline Credit or Tenants Lifeline Assistance, the remaining balance of the Special Utility Supplement shall be returned to the Treasurer, State of New Jersey.

10:69B-2.5 Responsibilities of the utility companies

(a) (No change.)

(b) Each electric and gas utility shall apply only one credit per utility account of an eligible residential utility customer.

(c)-(f) (No change.)

(a)

DIVISION OF FAMILY DEVELOPMENT

Assistance Standards Handbook
Deeming Income of Parents and Guardians of Adolescent Parents

Adopted Amendment: N.J.A.C. 10:82-3.14

Proposed: July 6, 1993 at 25 N.J.R. 2819(a).

Adopted: October 15, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: October 19, 1993 as R.1993 d.566, **without change.**

Authority: N.J.S.A. 44:10-3.

Effective Date: November 15, 1993.

Expiration Date: August 24, 1994.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

10:82-3.14 Deeming income of parents and guardians of adolescent parents

(a) (No change.)

(b) When an adolescent parent lives in the same home as his or her own parent(s) or legal guardian(s), the income of such parent(s) or legal guardian(s) shall be considered available to the eligible family in accordance with the following procedures. These rules do not apply if the parent(s) or guardian(s) receive(s) SSI or AFDC or if the adolescent parent is categorically eligible for the -N segment only. For the purposes of this section, the term parent shall include legal guardian.

1.-5. (No change.)

6. All income remaining shall be counted as unearned income available to the eligible unit and shall be counted toward total income (N.J.A.C. 10:82-1.2) and in the determination of grant amount.

i. In the event the eligible family unit is determined financially ineligible for AFDC cash assistance due to the inclusion of such deemed income, Medicaid eligibility for the dependent child(ren) of the adolescent parent shall be determined in accordance with N.J.A.C. 10:81-8.22(a)3.

(c) (No change.)

(b)

DIVISION OF YOUTH AND FAMILY SERVICES

In-Person Visits with Clients and Substitute Care Providers

Adopted New Rules: N.J.A.C. 10:133D-4

Proposed: June 7, 1993 at 25 N.J.R. 2210(a).

Adopted: October 21, 1993 by William Waldman, Commissioner, Department of Human Services.

Filed: October 21, 1993 as R.1993 d.587, **with a substantive change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4C-25, N.J.S.A. 30:4C-11 et seq., specifically 30:4C-44, and N.J.S.A. 9:6-8.8 et seq., specifically 9:6-8.15.

Effective Date: November 15, 1993.

Expiration Date: November 1, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Summary of Agency-Initiated Changes:
In N.J.A.C. 10:133D-4.2, the words "or guardian" have been removed, leaving the term "parent." The term "parent" is used exclusively throughout the rest of the subchapter, including the section on Scope. The definition of "parent or guardian" in N.J.A.C. 10:133-1.3 includes a "teacher, employee or volunteer . . . of an institution who is responsible for the child's welfare" and "a teaching staff member or other employee . . . of a day school." There is no reason why such persons would need or want on-going regularly scheduled visits from a Division representative. As indicated in the Scope section, it was not the Division's intention to include such persons in in-person visits.

Full text of the adoption follows (deletions from the proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 133D
CASE MANAGEMENT

SUBCHAPTERS 1.-3. (RESERVED)

SUBCHAPTER 4. IN-PERSON VISITS WITH CLIENTS AND SUBSTITUTE CARE PROVIDERS

10:133D-4.1 Authority

N.J.S.A. 30:4C-25 requires the Division of Youth and Family Services, Department of Human Services to regularly visit all children under its care, custody, and supervision.

10:133D-4.2 Purpose

The purpose of this subchapter is to establish criteria for determining the frequency and nature of in-person visits by a Division representative with each child, parent *[or guardian]*, and substitute care provider.

10:133D-4.3 Scope

The provisions of this subchapter shall apply to each child receiving services from the Division, his or her parent, and each substitute care provider of a Division supervised child, and to the Division.

10:133D-4.4 Definitions

The definitions in N.J.A.C. 10:133-1.3, Definitions, are hereby incorporated into this subchapter by reference.

10:133D-4.5 Purpose of in-person visits by the Division representative

(a) Each in-person visit by the Division representative shall be made for one or more of the following purposes:

1. To determine whether the child is receiving appropriate care and is safe from harm;

2. To determine whether the objectives of the case plan are being met;

3. To determine what progress is being made toward achieving the case goal; or

4. To determine whether barriers to achieving the case goal are being alleviated.

10:133D-4.6 Establishing a schedule for in-person visits

(a) The Division representative and supervisor shall establish a schedule for each child, his or her parent, and substitute care provider, based on the following:

1. The services to be provided directly by the Division representative;

2. The services to be provided by non-Division service providers;

3. The case goal; and

4. The assessed risk to the child.

(b) The supervisor and the Division representative shall monitor and modify the schedule when appropriate.

(c) Each established schedule for in-person visits shall fall between a range of once every week to once every 12 weeks, except as provided in (d) below.

(d) The office manager may approve an in-person visitation schedule of once every six months for a child, parent, or substitute care provider, when a child resides in:

1. A related or unrelated para-foster home where the only Division service is financial, and appropriate parenting has been demonstrated over a six month period of time during which the Division representative has made frequent in-person visits;

2. A formalized long-term foster care custody placement per P.L. 1992, c.139 and the foster parents have demonstrated the ability to handle all parental responsibilities without close monitoring by the Division; or

3. An out-of-State residential facility that precludes in-person visitation more frequently than once every six months.

(e) Whenever an in-person visitation schedule of once every six months has been approved under the provision of (d) above, the Division representative shall maintain monthly telephone contact between visits with all parties as well as with collateral individuals; for example, school personnel.

(f) The Division representative shall advise each child, his or her parent, and the substitute care provider of the schedule for in-person visits and any changes in the schedule.

10:133D-4.7 In-person visitation when a child is placed out of his or her own home

(a) In addition to the visits made in accordance with the provisions of N.J.A.C. 10:133D-4.6, Establishing a schedule for in-person visits, whenever a child is placed out of his or her own home:

1. Individual in-person visits with the child, the prior custodial parent, and the substitute care provider shall be made by the Division representative within five working days following the child's placement out of his or her own home;

2. The visit with the child shall occur in the home of the substitute care provider; and

3. The Division representative shall, whenever possible or appropriate, have an in-person visit in the home of the prior custodial parent or in the office within five working days following the child's placement.

10:133D-4.8 Change in placement

Following a change in the child's out-of-home placement, the Division representative shall have an in-person visit within five working days with the child and new substitute care provider.

10:133D-4.9 Residential placement

(a) The Division representative shall telephone the child within five working days of the child's residential placement, unless contraindicated by the individual treatment plan for the child.

(b) Within 20 working days of the placement, the Division representative shall visit the child and attend the treatment conference if one is scheduled at the time of the visit.

10:133D-4.10 Initial in-person visit

(a) In addition to the standards set by N.J.A.C. 10:133D-4.7, 4.8 and 4.9, the Division representative shall make an in-person visit to the child's residence within 20 working days when:

1. A case initially opened for services with the Division is assigned to the Division representative; or

2. The case is transferred from one Division representative to another. In this instance, the newly assigned Division representative shall make the in-person visit.

CORRECTIONS

(a)

THE COMMISSIONER

Inmate Discipline

Schedule of Sanctions for Prohibited Acts

Adopted Amendments: N.J.A.C. 10A:4-5.1, 5.2 and 5.3

Proposed: September 20, 1993 at 25 N.J.R. 4435(a).

Adopted: October 20, 1993 by William H. Fauver, Commissioner, Department of Corrections.

Filed: October 21, 1993 as R.1993 d.584, **without change.**

Authority: N.J.S.A. 30:1B-6 and 30:1B-10.

Effective Date: November 15, 1993.

Expiration Date: May 7, 1996.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

10A:4-5.1 Schedule of sanctions for prohibited acts committed at the Prison Complex, Adult Diagnostic and Treatment Center (ADTC) and Edna Mahan Correctional facility for Women (EMCF)

(a) A finding of guilt for any offense preceded by an asterisk (*) shall render the offender subject to one or more of the following sanctions:

1.-4. (No change.)

5. Loss of furlough privileges for up to two months;

6.-10. (No change.)

(b) A finding of guilt in the case of all other offenses shall render the offender subject to one or more of the following sanctions:

1.-4. (No change.)

5. Loss of furlough privileges for up to two months;

6.-10. (No change.)

(c) (No change.)

10A:4-5.2 Schedule of sanctions for prohibited acts committed at the Youth Complex

(a) A finding of guilt for prohibited acts preceded by an asterisk (*) shall render the offender subject to one or more of the following sanctions:

1.-3. (No change.)

4. Up to 14 hours extra duty, to be performed within a maximum of two weeks;

5. Loss of furlough privileges for up to two months;

6. Confiscation;

7. Any sanction prescribed for On-The-Spot Correction (see N.J.A.C. 10A:4-7);

Recodify existing 6.-8. as 8.-10. (No change in text.)

(b) A finding of guilt in the case of all other offenses shall render the offender subject to one or more of the following sanctions.

1.-5. (No change.)

6. Up to 14 hours extra duty, to be performed within a maximum of two weeks;

7. Loss of furlough privileges for up to two months;

8. Confiscation;

Recodify 8.-9. as 9.-10. (No change in text.)

(c) In addition to the sanctions in (a) and (b) above, administrative action may be taken by the Institutional Classification Committee upon the recommendation of the Disciplinary Hearing Of-

ficer/Adjustment Committee or the Superintendent. Such administrative action shall include, but not be limited to, the following:
1. (No change.)
2. Assigning to a treatment program;
Recodify existing 2.-5. as 3.-6. (No change in text.)

10A:4-5.3 Schedule of sanctions for prohibited acts committed at the New Jersey Training School for Boys, the Juvenile Medium Security Unit and the Lloyd McCorkle Training School for Boys and Girls

(a) A finding of guilt for prohibited acts preceded by an asterisk (*) shall render the offender subject to one or more of the following sanctions:
1. (No change.)
2. Up to two weeks confinement to room or housing unit;
Recodify existing 2.-3. as 3.-4. (No change in text.)
5. Up to 14 hours extra duty, to be performed within a maximum of two weeks;
Recodify existing 5.-7. as 6.-8. (No change in text.)

(b) A finding of guilt in the case of all other offenses shall render the offender subject to one or more of the following sanctions:
1. (No change.)
2. Up to two weeks confinement to room or boarding unit;
3. Loss of furlough privileges up to two months;
4. Up to 14 hours extra duty, to be performed within a maximum of two weeks;
Recodify existing 4.-7. as 5.-8. (No change in text.)

(c) In addition to the sanctions in (a) and (b) above, administrative action may be taken by the Institutional Classification Committee upon the recommendation of the Disciplinary Hearing Officer/Adjustment Committee or the Superintendent. Such administrative action shall include, but not be limited to, the following:
1. (No change.)
2. Assigning to a treatment program;
Recodify existing 2.-5. as 3.-6. (No change in text.)

(a)

THE COMMISSIONER

Blood Donation by Inmates
Autologous Blood Donation
Adopted Amendment: N.J.A.C. 10A:16-9.1

Proposed: September 7, 1993, at 25 N.J.R. 3920(a).
Adopted: October 15, 1993 by William H. Fauver, Commissioner, Department of Corrections.
Filed: October 19, 1993 as R.1993 d.567, **without change.**

Authority: N.J.S.A. 30:1B-6, 30:1B-10 and 26:2A-13 et seq.

Effective Date: November 15, 1993.
Expiration Date: July 6, 1997.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

10A:16-9.1 Blood donation

(a) In accordance with the Blood Safety Act of 1991 (N.J.S.A. 26:2A-13 et seq.), the donation of blood by inmates to other individuals (homologous) is prohibited. There shall be no exceptions to this prohibition.

(b) When medically necessary or appropriate, the donation of blood by an inmate for his or her exclusive use (autologous) in anticipated non-emergency, scheduled surgery will be permitted.

INSURANCE

(b)

DIVISION OF FINANCIAL EXAMINATIONS

Insurance Holding Company Systems
Adopted Concurrent New Rules: N.J.A.C. 11:1-35
Adopted Concurrent Amendment: N.J.A.C. 11:1-32.4

Proposed: September 7, 1993 at 25 N.J.R. 4275(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.554, **with technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e), 17:1-8.1, 17:27A-1 et seq., and P.L. 1993, c. 241.

Effective Date: October 15, 1993, Readoption of emergency new rules and amendments;
November 15, 1993, Changes upon adoption.
Expiration Date: January 31, 1996.

These new rules and amendment were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed rules and amendment is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for changes upon adoption, which are effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:
The Department of Insurance (Department) received six written comments from insurers and insurer trade associations as follows:
1. Prudential Insurance Company of America;
2. The Reinsurance Association of America;
3. Pennsylvania Millers Mutual Insurance Company;
4. Selective Insurance Company of America;
5. Royal Insurance; and
6. The American Insurance Association.

COMMENT: Two commenters objected to the inclusion of "bulk reinsurance" in the definition of "acquisition" in N.J.A.C. 11:1-35.2. The commenters stated that Department review of bulk reinsurance transactions is generally required under separate statutory provisions. The commenters suggested that this State adopt a separate statutory provision or regulation to address concerns with respect to bulk reinsurance.

RESPONSE: The definition set forth in the rules is consistent with the definition of "acquisition" set forth in the insurance holding company system statute at N.J.S.A. 17:27A-1j. Accordingly, the Department believes that no change is required.

COMMENT: One commenter suggested that the last two sentences set forth in N.J.A.C. 11:1-35.3(c), with respect to the signing of copies of Exhibit C (summary of registration statement), should be codified under N.J.A.C. 11:1-35.3(b).

RESPONSE: Upon review of the commenter's suggestion, the Department has determined it appropriate to recodify N.J.A.C. 11:1-35.3(c). The Department notes that in developing these rules, the Department relied on the Insurance Holding Company System Model Regulation adopted by the National Association of Insurance Commissioners (NAIC). However, the codification of the model regulation is not necessarily consistent with this State's codification rules. In the interest of consistency, uniformity, and clarity with respect to the requirements in N.J.A.C. 11:1-35.3(c), the Department has recodified N.J.A.C. 11:1-35.3(c) upon adoption as paragraphs 1 and 2 in N.J.A.C. 11:1-35.3(b).

COMMENT: One commenter expressed concern with N.J.A.C. 11:1-35.10, which requires an insurer to provide prior notice to the Department of specified transactions. The commenter noted that prior to its enactment, the insurance holding company systems statute was amended to provide at N.J.S.A. 11:27A-4a(6) that the Commissioner may by regulation specify certain types of transactions that need not be submitted for prior review if he or she determines that those transactions would not have a significant impact on the financial condition or methods of operation of the insurer. The commenter noted that the rules do not specify any such transactions which are exempt from prior review.

The commenter stated that all management and service agreements and cost sharing arrangements are not material. It believes that in its case it would be unusual for any such arrangement to be material in the aggregate, and less likely for any such arrangement to have a potential adverse affect on policyholders. The commenter stated that in many cases these arrangements involve routine services valued in the thousands or tens of thousands of dollars per year. The commenter believes that to require prior approval of each such arrangement would impose undue administrative burdens both on insurers and the Department. The commenter expressed similar concerns with respect to the requirement that insurers notify the Department within 30 days of any investments in 10 percent or more of the voting stock of any corporation.

The commenter therefore recommended the rules be revised to provide: (1) a "three percent of admitted assets" threshold for prior notice of management agreements, service agreements and cost sharing arrangements; and (2) a "three percent of admitted assets" threshold on the requirement that the Commissioner be notified within 30 days of any investment of the domestic insurer in any one corporation if the total investment in that corporation by the holding company system exceeds 10 percent of that corporation's voting securities. In other words, the commenter suggested that the rules be revised to provide that an insurer need not notify the Department of the above-referenced transactions unless such transaction represents at least three percent of the insurer's admitted assets. The commenter noted that the current rules provide no threshold of materiality (that is, all such transactions must be reported to the Department).

The commenter also suggested, with respect to the notice of requirement of investments in 10 percent or more of voting stock, that the rules clarify that the statutory provision applies only to investments by an insurer's general account and the proprietary accounts of entities in its holding company system, and does not apply to investments made through separate accounts (except to the extent of surplus in such accounts). The commenter suggested that the rules may provide that voting stock held by separate accounts is included to the extent such accounts are established or used as a means to circumvent the notification provision.

RESPONSE: The Department notes that the statute grants the Commissioner the ability to set a "materiality standard" for the reporting of transactions to the Department. However, the Commissioner has not yet exercised this authority. The Department notes that setting the standard requires a careful review of all relevant information to determine a reasonable and appropriate materiality threshold. This review was not completed as of the date of the adoption and concurrent proposal of these rules on August 16, 1993. In addition, the Department notes that the changes as suggested by the commenter could not be made upon adoption in any case since the establishment of a materiality standard must be proposed in order to afford all interested parties notice and an opportunity to comment. The Department will continue to review this matter to determine whether an appropriate materiality standard may be established. The Department also notes that, with respect to management and service agreements and cost sharing arrangements, insurers are required only to file a brief description of certain aspects of the transactions (see Item 6 of Exhibit D). The Department thus believes that the current rules should not impose an undue burden on insurers.

Finally, with respect to the suggested revision regarding investments from general or special accounts, the Department notes that this notice requirement is established by statute, N.J.S.A. 17:27A-4a(5), and tracks verbatim language in the NAIC model law, which has been adopted by many states. The Department is not aware of any problems raised by this provision. Moreover, the rules do not address applicability of the notice requirement set forth in N.J.S.A. 17:27A-4a(5) based on the accounts from which such investment is made. The comment thus appears to be outside the scope of the proposal. Further, the commenter did not set forth reasons for the proposed change or the issues or concerns it is intended to address. This issue however may relate to the commenter's concerns with respect to materiality as discussed above. To the extent this comment is related to materiality it may be considered in the development of any materiality standard.

COMMENT: One commenter requested clarification with respect to N.J.A.C. 11:1-35.8. This rule provides that an authorized insurer filing on behalf of an affiliated insurer which is required to register pursuant to N.J.S.A. 17:27A-3 may, in lieu of filing the registration statement in the format of Exhibit B, file a copy of the registration or similar report which is required to be filed in its state of domicile (provided the statement or report contains substantially similar information required to be furnished in Exhibit B and the filing insurer is the "principal insurer" in the insurance holding company system). The commenter stated that it is domiciled in Pennsylvania and inquired whether Pennsylvania's holding company requirements and forms "meet with New Jersey's approval."

RESPONSE: The commenter is seeking prior approval as to whether it may make consolidated or alternative filings with New Jersey, rather than commenting on a particular provision or provisions of the rules. The particular insurer involved should refer to N.J.A.C. 11:1-35.8(d), which provides that prior approval is not required, except in the case of filings by unauthorized insurers pursuant to N.J.A.C. 11:1-35.8(c).

The Department also notes that it would consider the requirements imposed by any state which has been "accredited" by the NAIC to have requirements substantially similar to those of this State. In addition, the Department would consider a state which is not accredited to have substantially similar requirements if it has enacted the relevant statutory and regulatory provisions as set forth in the most recent NAIC model insurance holding company systems act and regulation adopted by the NAIC, or has enacted provisions substantially similar thereto.

COMMENT: One commenter stated that as it interprets the rules, it is required to file an Exhibit C only in states where the commissioner has requested such information.

RESPONSE: Pursuant to N.J.S.A. 11:1-35.7(b), an insurer which is required to file an annual registration statement pursuant to N.J.S.A. 17:27A-3 is required to also file the information set forth on Exhibit C, and to file a copy of Exhibit C in each state in which the insurer is authorized to do business if requested by the Commissioner or other regulatory official of that state. If the insurer is not required to file a registration statement in this State, the insurer would be required to file an Exhibit C in this State only when requested by the Commissioner. The Department notes that these are the requirements pursuant to this State's statutes and rules; the requirements of other states in which the insurer is authorized to transact business may differ.

COMMENT: One commenter noted that pursuant to N.J.A.C. 11:1-35.7(c), an insurer is required to file an amendment to Exhibit B within 15 days after the end of any month in which there is a material change to the information required in the annual registration statement. The commenter requested clarification with respect to what would be considered a material change.

RESPONSE: The definition of "material" is presently set forth in N.J.S.A. 17:27A-3c. Accordingly, changes in any of the information required to be submitted pursuant to N.J.S.A. 17:27A-3b must be reported, except that changes with respect to sales, purchases, exchanges, loans or extensions of credit, investments, or guarantees or other contingent obligations involving one half of one percent or less of an insurer's admitted assets as of December 31 next preceding are not material and thus need not be reported.

COMMENT: One commenter expressed concern with N.J.A.C. 11:1-35.10, with respect to requirements for payments of ordinary dividends. The commenter stated that the rule provides that an ordinary dividend may not be paid until 30 days after the Commissioner has received notice of its declaration. The commenter stated that because of the procedures generally utilized by insurer subsidiaries to pay dividends to their ultimate parent, "contingent" declaration of dividends, as provided at N.J.S.A. 17:27A-4, is inappropriate. The commenter stated that when a company declares a dividend, the Board must be certain that the dividend can be paid. The commenter thus believes that the only way to be certain dividends may be paid is to ensure that the statutory notice period lapses before the company meets to declare a dividend.

The commenter also noted that pursuant to N.J.S.A. 17:27A-4c(1), for good cause shown, the Commissioner may reduce the notification period to not less than 10 days. The commenter suggested that the Commissioner require only 15 days notice for submissions of ordinary dividends by companies that have a history of sound financial condition. Extraordinary dividends would continue to be submitted with at least 30 days prior notice. The commenter further suggested that insurers be permitted to submit notice of proposed dividends prior to declaration.

The commenter additionally objected to the requirement in N.J.A.C. 11:1-35.10(b)5, which requires that the notice of a dividend include a balance sheet and statement of income for the period from the last filed annual statement to the end of the month preceding the month the request is submitted. The commenter stated that this requirement is unnecessary and inappropriate since companies are required to submit

quarterly statements. In addition, the commenter believes that preparation of such a document would be a "practical impossibility" and noted that quarterly statements are not due until 45 days after the end of the quarter.

Finally, the commenter stated that the rule should specifically define the standards the Department would utilize in determining whether an insurer is in a hazardous financial condition for purposes of N.J.S.A. 17:27A-4c(1).

RESPONSE: Upon review of the commenter's concerns, the Department has determined that no change is required. The Department initially notes that the time frames for submission and review of requests to make ordinary and extraordinary dividends are established by statute at N.J.S.A. 17:27A-4, not N.J.A.C. 11:1-35.10. Accordingly, the comments with respect to time frames for submission and review of requests for dividends are outside the scope of the proposal. The Department notes, however, that the 30 day review period is a maximum and that the Department expects to complete its review of such requests as expeditiously as possible. The Department also does not believe it would be appropriate to provide for a 15 day review period for submissions from any company that has a "history of sound financial condition". This would be inconsistent with N.J.S.A. 17:27A-4c(1), which allows the Commissioner to reduce the notification period "for good cause shown," which ordinarily means on a case-by-case basis. Moreover, relying solely on an insurer's financial history, while relevant, would not recognize other factors, including the insurer's present financial condition, the effect that payment of the dividend would have on the insurer's financial condition, and the amount of the dividend, which the Department would consider in determining whether to limit or disallow the dividend as required pursuant to N.J.S.A. 17:27A-4c(1).

The Department similarly does not believe that preparation of the balance sheet as required pursuant to N.J.A.C. 11:1-35.10(b)5 should be burdensome or impossible, as the commenter maintained. This requirement reflects the national standard as set forth in the Insurance Holding Company System Model Regulation adopted by the NAIC, which has been adopted by a majority of other states, including Delaware, Georgia, Maryland, North Carolina and South Carolina, where the commenter is authorized to transact business.

Finally, the Department will utilize the standards set forth in N.J.A.C. 11:2-27 in determining whether the insurer is in a hazardous financial condition for purposes of N.J.S.A. 17:27A-4c(1).

COMMENT: Two commenters objected to the fees imposed for review of extraordinary and ordinary dividends in the amounts of $1,000 and $500.00, respectively. One commenter stated that the fees are excessive and exceed that imposed by other states. The commenter believes that the fees may be viewed as a penalty for the insurer seeking to pay a dividend. Another commenter stated that the two criteria utilized by the Commissioner in determining whether to disallow or limit the payments of dividends are part of the Department's ongoing responsibility to maintain solvency. Because of the Department's ongoing review of financial solvency, and especially because ordinary dividends are, by their nature, part of an insurer's ordinary course of business, the commenter suggested that the fees be deleted.

RESPONSE: Upon review of the commenters' concerns, the Department has determined not to change this provision. The Department does not believe that the fees are a "penalty" for insurers seeking to pay dividends, but rather reflect additional costs to the Department to perform the required reviews of all dividends, including ordinary dividends, within a limited period of time as required by N.J.S.A. 17:27A-4.

Full text of the adopted new rules follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*):

11:1-32.4 Fees; general

(a) (No change.)

(b) The following fees shall be paid for services provided by the Commissioner in addition to those set forth in (a) above as follows:

1.-11. (No change.)

12. Processing an application for the issuance of a Certificate of Registration pursuant to N.J.A.C. 11:3-3—$1,000; processing an application of renewal of a Certificate of Registration—$250.00;

13. Processing an application for issuance or renewal of a Certificate of Order Granting Exemption from Insuring Liability for Compensation pursuant to N.J.A.C. 11:2-33—$1,000; and

14. Each submission or resubmission for review of payment of an extraordinary dividend or distribution pursuant to N.J.S.A. 17:27A-4—$1,000; each submission or resubmission for review of payment of an ordinary dividend or distribution pursuant to N.J.S.A. 17:27A-4—$500.00.

SUBCHAPTER 35. INSURANCE HOLDING COMPANY SYSTEMS

11:1-35.1 Purpose and scope

(a) The purpose of this subchapter is to set forth filing and procedural requirements governing the filing of required information with respect to the acquisition of control of, or merger with, a domestic insurer, and registration and notification requirements for insurers which are members of an insurance holding company system, pursuant to N.J.S.A. 17:27A-1 et seq.

(b) This subchapter shall apply to any person, insurer, subsidiary or insurance holding company system subject to the requirements set forth in N.J.S.A. 17:27A-1 et seq.

11:1-35.2 Definitions

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

"Acquisition" means any agreement, arrangement or activity, the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, and assets, and bulk reinsurance and mergers.

"Affiliate" means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

"Alien insurer" means an insurer formed under the laws of any country other than the United States, its states, districts, territories, commonwealth and possessions.

"Authorized insurer" means a foreign or alien insurer, duly authorized by a certificate of authority issued by the Commissioner to transact insurance in this State pursuant to N.J.S.A. 17:32-1 et seq. or 17B:23-1 et seq.

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

"Control" is as defined at N.J.S.A. 17:27A-1c.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of this State.

"Executive officer" means chief executive officer, chief operating officer, chief financial officer, treasurer, secretary, controller, and any other individual performing functions corresponding to those performed by the foregoing officers under whatever title.

"Foreign insurer" means an insurer formed under the laws of a jurisdiction of the United States other than this State, and shall include an alien insurer except where clearly noted otherwise.

"Insurance holding company system" means two or more affiliated persons, one or more of which is an insurer.

"Insurer" means any person or persons, corporation, partnership, or company authorized by the laws of this State to transact the business of insurance in this State, except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or a political subdivision of a state.

"Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

"Principal insurer" means the insurer with the largest amount of direct written premium within the holding company system as shown by the last filed annual statement.

"Subsidiary" of a specified person is an affiliate controlled by such person directly, or indirectly through one or more intermediaries.

"Ultimate controlling person" means that person which is not controlled by any other person.

"Unauthorized insurer" means an insurer that is not an authorized insurer.

"Voting security" includes any security convertible into or evidencing a right to acquire a voting security.

11:1-35.3 Forms; general requirements

(a) All statements required to be filed pursuant to N.J.S.A. 17:27A-2, 17:27A-3 and 17:27A-4 shall be submitted in accordance with the forms set forth at Exhibits A, B, C, and D, in the Appendix incorporated herein by reference, as applicable. The forms shall be considered blank forms which are to be filled in. The statements filed shall contain the numbers and captions of all items, but the text of the items may be omitted provided the answers thereto are prepared in such a manner as to indicate clearly the scope and coverage of the items. All instructions, whether appearing under the items of the form or elsewhere therein, are to be omitted. Unless expressly provided otherwise, if any item is inapplicable or the answer thereto is in the negative, an appropriate statement to that effect shall be made.

(b) Seven complete copies of each Exhibit A statement, and one copy of each Exhibit B, C and D, including exhibits and all other papers and documents filed as a part thereof, shall be filed with the Commissioner by personal delivery or mail addressed to:

Holding Company Submissions
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, NJ 08625

*[(c)]**1.* A copy of Exhibit C shall be filed in each state in which an insurer is authorized to do business, if the commissioner or other regulatory official of that state has notified the insurer of its request in writing, in which case the insurer shall file such forms within 30 days of receipt of the notice.

**2.* At least one of the copies shall be manually signed in the manner prescribed on the form. Unsigned copies shall be conformed. If the signature of any person is affixed pursuant to a power of attorney or other similar authority, a copy of the power of attorney or other authority shall also be filed with the statement.

*[(d)]**(c)* Statements and information required pursuant to Exhibit A shall be in loose-leaf form inserted into standard two-ring or three-ring binders. The loose-leaf sheets used shall be eight and one-half inches wide and 11 inches long and punched for two-ring and three-ring binders as appropriate. In the case of information required pursuant Exhibits A, B, C or D, exhibits and financial statements, unless specifically prepared for the filing, may be submitted in their original size. All copies of any statement, financial statements, or exhibits shall be clear, easily readable and suitable for photocopying. Debits in credit categories and credits in debit categories shall be designated so as to be clearly distinguishable as such on photocopies. Statements shall be in the English language and monetary values shall be stated in United States currency. If any exhibit or other paper or document filed with the statement is in a foreign language, it shall be accompanied by a translation into the English language and any monetary value shown in a foreign currency shall be converted into United States currency.

11:1-35.4 Forms; incorporation by reference, summaries and omissions

(a) Information required pursuant to any item set forth in Exhibits A, B or D may be incorporated by reference in an answer or partial answer to any other item. Information contained in any financial statement, annual report, proxy statement, statement filed with a governmental authority, or any other document may be incorporated by reference in the answer or partial answer to any item of Exhibits A, B or D provided such document or paper is filed as an appendix or exhibit to the appropriate Exhibit A, B or D. Matter shall not be incorporated by reference in any case where such incorporation would render the statement incomplete, unclear or confusing.

(b) Where an item requires a summary or outline of the provisions of any document, only a brief statement shall be made as to the pertinent provisions of the document. In addition to such statement, the summary or outline may incorporate by reference particular parts of any exhibit or document currently on file with the Commissioner which was filed within three years and may be qualified in its entirety by such reference.

11:1-35.5 Forms, additional information and exhibits

(a) In addition to the information expressly required to be included in Exhibits A, B, C and D, the person making the filing shall include such further material information, if any, as may be necessary to make the information contained therein not misleading, as well as any additional information the Commissioner may specifically request from a particular filer.

(b) The person making the filing may also file such exhibits as it may desire in addition to those expressly required by the statement. Such exhibits shall be so marked as to indicate clearly the subject matters to which they refer. Changes to Exhibits A, B, C and D shall include on the top of the cover page the phrase: "Change No. (insert number) to" and shall indicate the date of the change rather than the date of the original filing.

11:1-35.6 Acquisition of control; statement filing; procedures

(a) A person required to file a statement pursuant to N.J.S.A. 17:27A-2 shall furnish the required information set forth in Exhibit A.

(b) The applicant shall advise the Commissioner within two business days of any changes in the facts or information submitted pursuant to (a) above arising subsequent to the date such information was furnished.

(c) If the person being acquired is deemed to be a "domestic insurer" solely because of the provisions of N.J.S.A. 17:27A-2a, the name of the domestic insurer on the cover page shall be indicated as follows:

1. "ABC Insurance Company, a subsidiary of XYZ Holding Company."

(d) Where a domestic insurer, as defined in N.J.S.A. 17:27A-2a, is being acquired, references to "the insurer" contained in Exhibit A shall refer to both the domestic subsidiary insurer and the person being acquired.

(e) The time frames for the scheduling of the public hearing on the proposed acquisition as set forth in N.J.S.A. 17:27A-2d(2) shall not commence until all of the information required to be contained in an acquisition statement as set forth in N.J.S.A. 17:27A-2 and this subchapter has been received by the Commissioner.

(f) Upon the scheduling of the hearing, the acquiring party shall cause notice of the hearing to be published in not less than two newspapers of general circulation in this State. Such notice shall include, but not be limited to, the name of the acquiring party, the name of the insurer proposed to be acquired, and the time and place for the hearing. Such notice shall be published not later than seven days, nor earlier than 14 days, prior to the scheduled date of the hearing.

(g) A verbatim transcript of a hearing held pursuant to N.J.S.A. 17:27A-2d shall be made, and the costs thereof shall be borne by the acquiring party.

(h) Until the day of the hearing, any information received pursuant to N.J.S.A. 17:27A-2b or this subchapter as part of an acquisition of control statement filing shall be confidential and shall not be subject to public inspection or copying pursuant to the "Right to Know" law, N.J.S.A. 47:1A-1 et seq.

11:1-35.7 Annual registration of insurers

(a) An insurer required to file an annual registration statement pursuant to N.J.S.A. 17:27A-3 shall furnish the information set forth in Exhibit B within the time frames set forth in N.J.S.A. 17:27A-3a.

(b) An insurer required to file an annual registration statement pursuant to N.J.S.A. 17:27A-3 also shall furnish information set forth on Exhibit C. The insurer shall file a copy of Exhibit C in each state in which the insurer is authorized to do business, if requested by the Commissioner or other regulatory official of that state.

(c) The insurer shall file an amendment to Exhibit B within 15 days after the end of any month in which there is a material change to the information provided in the annual registration statement. Amendments shall be filed in the format of Exhibit B. Only items

which are being amended shall be reported. Each such amendment shall include at the top of the cover page "Amendment No. (insert number) to Form B for (insert year)" and shall indicate the date of the change rather than the date of the original filing.

11:1-35.8 Alternative and consolidated registrations

(a) Any authorized insurer may file a registration statement on behalf of any affiliated insurer or insurers which are required to register pursuant to N.J.S.A. 17:27A-3. The registration statement may include information not required by N.J.S.A. 17:27A-1 et seq. regarding any insurer in the insurance holding company system even if such insurer is not authorized to do business in this State. In lieu of filing a registration statement in the format of Exhibit B, the authorized insurer may file a copy of the registration or similar report which it is required to file in its state of domicile, provided that:

1. The statement or report contains substantially similar information required to be furnished on Exhibit B; and

2. The filing insurer is the principal insurer in the insurance holding company system.

(b) An insurer filing a registration statement or report in lieu of Exhibit B on behalf of an affiliated insurer shall provide a brief statement of facts to substantiate the filing insurer's claims that it, in fact, is the principal insurer in the insurance holding company system.

(c) With the prior approval of the Commissioner, an unauthorized insurer may follow any of the procedures which could be done by an authorized insurer under paragraph (a) above.

(d) Except as provided at (c) above, any insurer may make consolidated or alternate filings as set forth in this section without the prior approval of the Commissioner. The Commissioner, however, may require individual filings at any time if he or she deems such filings necessary in the interest of clarity, ease of administration or the public good.

11:1-35.9 Disclaimers and termination of registration

(a) A disclaimer of affiliation or a request for termination of registration claiming that a person does not, or will not upon the taking of some proposed action, control another person (hereinafter referred to as the "subject") shall contain the following information:

1. The number of authorized, issued and outstanding voting securities of the subject;

2. With respect to the person whose control is denied and all affiliates of such person, the number and percentage of shares of the subject's voting securities which are held of record or known to be beneficially owned, and the number of such shares concerning which there is a right to acquire, directly or indirectly;

3. All material relationships and bases for affiliation between the subject and the person whose control is denied and all affiliates of such person; and

4. A statement explaining why such person should not be considered to control the subject.

(b) A request for termination of registration shall be deemed to have been granted unless the Commissioner, within 30 days after receipt of the request, notifies the registrant otherwise.

11:1-35.10 Transactions subject to prior notice

(a) An insurer required to give notice of a proposed transaction pursuant to N.J.S.A. 17:27A-4 shall furnish the required information as set forth in Exhibit D within the applicable time frames set forth in N.J.S.A. 17:27A-4.

(b) Notification of extraordinary dividends and any other ordinary dividend distribution to shareholders shall include the following information:

1. The amount of the proposed dividend;

2. The date established for payment of the dividend;

3. A statement as to whether the dividend is to be in cash or other property. If the dividend is in property, a description thereof shall be provided, as well as a description of its cost, fair market value, and an explanation of the basis for valuation;

4. A copy of the work paper calculations determining whether the proposed dividend is an extraordinary dividend as defined in N.J.S.A. 17:27A-4c(2)(b). The work paper shall include the following information:

i. The amounts, dates and form of payment of all dividends or distributions (including regular dividends but excluding distributions of the insurer's own securities) paid within the period of 12 consecutive months ending on the date fixed for payment of the proposed dividend for which approval is sought and commencing on the day after the same day of the same month in the last preceding year;

ii. The insurer's surplus as regards policyholders (total capital and surplus) as of the 31st of December next preceding;

iii. If the insurer is a life insurer, the net gain from operations less realized capital gains for the 12-month period ending the 31st day of December next preceding; and

iv. If the insurer is not a life insurer, the net income less realized capital gains for the 12-month period ending the 31st day of December next preceding;

5. A balance sheet and statement of income for the period intervening from the last annual statement filed with the Commissioner and the end of the month preceding the month in which the request for dividend approval is submitted;

6. A brief statement as to the effect of the proposed dividend upon the insurer's surplus and the reasonableness of surplus in relation to the insurer's outstanding liabilities and the adequacy of surplus relative to the insurer's financial needs; and

7. The non-refundable filing fee as set forth at N.J.A.C. 11:1-32.4(b)14.

11:1-35.11 Adequacy of surplus

In determining the adequacy and reasonableness of an insurer's surplus, the Commissioner shall consider the factors set forth in N.J.S.A. 17:27A-4b, among others, and need not consider any single factor as necessarily controlling. The Commissioner may consider the net effect of all of these factors plus other factors bearing on the financial condition of the insurer. In comparing the surplus maintained by other insurers, the Commissioner shall consider the extent to which each of these factors varies from company to company and in determining the quality and liquidity of investments in subsidiaries, the Commissioner shall consider the individual subsidiary and may discount or disallow its valuation to the extent that, in his or her judgment, the individual investment so warrants.

11:1-35.12 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

APPENDIX

EXHIBIT A

Form A
STATEMENT REGARDING THE ACQUISITION OF CONTROL OF OR MERGER WITH A DOMESTIC INSURER

_____

Name of Domestic Insurer

BY

_____

Name of Acquiring Person (Applicant)

filed with the Insurance Department of the State of

NEW JERSEY

Dated: _____, 19____

Name, title, address and telephone number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

_____

ITEM 1. INSURER AND METHOD OF ACQUISITION

State the name and address of the domestic insurer to which this application relates and a brief description of how control is to be acquired.

ITEM 2. IDENTITY AND BACKGROUND OF THE APPLICANT

(a) State the name and address of the applicant seeking to acquire control over the insurer.

(b) If the applicant is not an individual, state the nature of its business operations for the past five years or for such lesser period as such person and any predecessors thereof shall have been in existence. Briefly describe the business intended to be done by the applicant and the applicant's subsidiaries.

(c) Furnish a chart or listing clearly presenting the identities of the inter-relationships among the applicant and all affiliates of the applicant, regardless of the amount of the affiliate's total assets. Indicate in such chart or listing the percentage of voting securities of each such person which is owned or controlled by the applicant or by any other such person. If control of any person is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (for example, corporation, trust, partnership) and the state or other jurisdiction of domicile. If court proceedings involving a reorganization or liquidation are pending with respect to any such person, indicate which person, and set forth the title of the court, nature of proceedings and the date when commenced.

ITEM 3. IDENTITY AND BACKGROUND OF INDIVIDUALS ASSOCIATED WITH THE APPLICANT

State the following with respect to (1) the applicant if (s)he is an individual or (2) all persons who are directors, executive officers or owners of 10 percent or more of the voting securities of the applicant is not an individual.

(a) Name and business address;

(b) Present principal business activity, occupation or employment including position and office held and the name, principal business and address of any corporation or other organization in which such employment is carried on;

(c) Material occupation, positions, offices or employment during the last five years, giving the starting and ending dates of each and the name, principal business and address of any business, corporation or other organization in which each such occupation, position, office or employment was carried on; if any such occupation, position, office or employment required licensing by or registration with any federal, state or municipal governmental agency, indicate such fact, the current status of such licensing or registration, and an explanation of any surrender, revocation, suspension or disciplinary proceedings in connection therewith.

(d) Whether or not such person has ever been convicted in a criminal proceeding (excluding minor traffic violations) during the last ten years and, if so, give the date, nature of conviction, name and location of court, and penalty or other disposition of the case.

ITEM 4. NATURE, SOURCE AND AMOUNT OF CONSIDERATION

(a) Describe the nature, source and amount of funds or other consideration used or to be used in effecting the merger or other acquisition of control. If any part of the same is represented or is to be represented by funds or other consideration borrowed or otherwise obtained for the purpose of acquiring, holding or trading securities, furnish a description of the transaction, the names of the parties thereto, the relationship, if any, between the borrower and the lender, the amounts borrowed or to be borrowed, and copies of all agreements, promissory notes and security arrangements relating thereto.

(b) Explain the criteria used in determining the nature and amount of such consideration.

(c) If the source of the consideration is a loan made in the lender's ordinary course of business and if the applicant wishes the identity of the lender to remain confidential, he must specifically request that the identity be kept confidential.

ITEM 5. FUTURE PLANS OF INSURER

Describe any plans or proposals which the applicant may have to declare an extraordinary dividend, to liquidate such insurer, to sell its assets to or merge it with any person or persons or to make any other material change in its business operations or corporate structure or management.

ITEM 6. VOTING SECURITIES TO BE ACQUIRED

State the number of shares of the insurer's voting securities which the applicant, its affiliates and any person listed in Item 3 plan to acquire, and the terms of the offer, request, invitation, agreement or acquisition, and a statement as to the method by which the fairness of the proposal was determined. A copy of the final executed purchase agreement shall also be attached to this statement, unless the insurer being acquired is in rehabilitation. In such a case, a copy of the draft purchase agreement shall nevertheless be attached, which shall reflect the general terms for the purchase as agreed to by the parties as of the date of the filing.

ITEM 7. OWNERSHIP OF VOTING SECURITIES

State the amount of each class of any voting security of the insurer which is beneficially owned or concerning which there is a right to acquire beneficial ownership by the applicant, its affiliates or any person listed in Item 3.

ITEM 8. CONTRACTS, ARRANGEMENTS OR UNDERSTANDINGS WITH RESPECT TO VOTING SECURITIES OF THE INSURER

Give a full description of any contracts, arrangements or understandings with respect to any voting security of the insurer in which the applicant, its affiliates or any person listed in Item 3 is involved, including but not limited to transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

ITEM 9. RECENT PURCHASES OF VOTING SECURITIES

Describe any purchase of any voting securities of the insurer by the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this Statement. Include in such description the dates of purchase, the names of the purchasers, and the consideration paid or agreed to be paid therefor. State whether any such shares so purchased are hypothecated.

ITEM 10. RECENT RECOMMENDATIONS TO PURCHASE

Describe any recommendations to purchase any voting security of the insurer made by the applicant, its affiliates or any person listed in Item 3, or by anyone based upon interviews or at the suggestion of the applicant, its affiliates or any person listed in Item 3 during the 12 calendar months preceding the filing of this statement.

ITEM 11. AGREEMENTS WITH BROKER-DEALERS

Describe the terms of any agreement, contract or understanding made with any broker-dealer as to solicitation of voting securities of the insurer for tender and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

ITEM 12. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits shall be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the persons identified in Item 2(c) (including trusts, partnerships or corporations) for the preceding five fiscal years (or for such lesser period as such applicant and its affiliates and any predecessors thereof shall have been in existence), and similar information covering the period from the end of such person's last fiscal year, if such information is available. Such statements may be prepared on either an individual basis, or, unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

The annual financial statements of the applicant shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the applicant and the results of its operations for the year then ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. In the case of annual statements for individuals, in lieu of an annual statement certified by an independent certified public accountant, the Commissioner may accept annual statements for individuals that conform with the Institute of Certified Public Accountants Guidelines for Financial Compilation, or such similar guidelines acceptable to the Commissioner. If the applicant is an insurer which is actively engaged in the business of insurance, the financial statements need not be certified, provided they are based on the Annual Statement of such person filed with the insurance department of the person's domiciliary state and are in accordance with the requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) File as exhibits copies of all tender offers for, requests or invitations for, tenders of, exchange offers for, and agreements to acquire or exchange any voting securities of the insurer and (if distributed) of additional soliciting material relating thereto, any proposed employment, consultation, advisory or management contracts concerning the insurer, annual reports to the stockholders of the insurer and the applicant for the last two fiscal years, and any additional documents or papers required by Form A or N.J.A.C. 11:1-35.3.

ITEM 13. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-2

_____ has caused this application to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19____

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached application dated _____, 19____, for and on behalf of _____; that (s)he is the _____ of (Name of Applicant) (Title of Officer) such company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

EXHIBIT B

FORM B

INSURANCE HOLDING COMPANY SYSTEM ANNUAL REGISTRATION STATEMENT

Filed with the Insurance Department of the State of

NEW JERSEY

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning this Statement Should be Addressed:

_____

_____

_____

ITEM 1. IDENTITY AND CONTROL OF REGISTRANT

Furnish the exact name of each insurer registering or being registered (hereinafter called "the Registrant"), the home office address and principal executive offices of each; the date on which each Registrant became part of the insurance company system; and the method(s) by which control of each Registrant was acquired and is maintained.

ITEM 2. ORGANIZATIONAL CHART

Furnish a chart or listing clearly presenting the identities of and interrelationships among all affiliated persons within the insurance holding company system, regardless of the amount of the affiliate's total assets. The chart or listing should show the percentage of each class of voting securities of each affiliate which is owned, directly or indirectly, by another affiliate. If control of any person within the system is maintained other than by the ownership or control of voting securities, indicate the basis of such control. As to each person specified in such chart or listing indicate the type of organization (for example, corporation, trust, partnership) and the state or other jurisdiction of domicile.

ITEM 3. THE ULTIMATE CONTROLLING PERSON

As to the ultimate controlling person in the insurance holding company system, furnish the following information:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure of the person, that is, corporation, partnership, individual, trust, etc.

(e) The principal business of the person.

(f) The name and address of any person who holds or owns 10 percent or more of any class of voting security, the class of such security, the number of shares held of record or known to be beneficially owned, and the percentage of class so held or owned.

(g) If court proceedings involving a reorganization or liquidation are pending, indicate the title and location of the court, the nature of proceedings and the date when commenced.

ITEM 4. BIOGRAPHICAL INFORMATION

Furnish the following information for the directors and executive officers of the ultimate controlling person: the individual's name and address, his or her principal occupation and all offices and positions held during the past five years, and any conviction of crimes other than minor traffic violations during the past ten years.

ITEM 5. TRANSACTIONS AND AGREEMENTS

Briefly describe the following agreements in force, and transactions currently outstanding or which have occurred during the last calendar year between the Registrant and its affiliates:

(1) Loans, other investments, or purchases, sales or exchanges of securities of the affiliates by the Registrant or of the Registrant by its affiliates;

(2) Purchases, sales or exchanges of assets;

(3) Transactions not in the ordinary course of business;

(4) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the Registrant's assets to liability, other than insurance contracts entered into in the ordinary course of the Registrant's business;

(5) All management agreements, service contracts and all cost-sharing arrangements;

(6) Reinsurance agreements;

(7) Dividends and other distributions to shareholders, including the declarations and authorizations thereof;

(8) Consolidated tax allocation agreements; and

(9) Any pledge of the Registrant's stock and/or of the stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system.

No information need be disclosed if such information is not material.

Sales, purchases, exchanges, loans or extensions of credit, investments, guarantees or other contingent obligations involving 0.5 percent or less of the Registrant's admitted assets as of the 31st day of December next preceding shall not be deemed material.

The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include at least the following: the nature and purpose of the transaction, the nature and amounts of any payments or transfers of assets between the parties, the identity of all parties to such transaction, and relationship of the affiliated parties to the Registrant.

ITEM 6. LITIGATION OR ADMINISTRATIVE PROCEEDINGS

A brief description of any litigation or administrative proceedings of the following types either then pending or concluded within the preceding fiscal year, to which the ultimate controlling person or any of its directors or executive officers was a party or of which the property of any such person is or was the subject; give the names of the parties and the court or agency in which such litigation or proceedings is or was pending:

(a) Criminal prosecutions or administrative proceedings by any government agency or authority which may be relevant to the trustworthiness of any party thereto; and

(b) Proceedings which may have a material effect upon the solvency or capital structure of the ultimate controlling person including, but not necessarily limited to, bankruptcy, receivership or other corporate reorganizations.

ITEM 7. STATEMENT REGARDING PLAN OR SERIES OF TRANSACTIONS

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions, the purpose of which is to avoid statutory threshold amounts and the review that might otherwise occur.

ITEM 8. FINANCIAL STATEMENTS AND EXHIBITS

(a) Financial statements and exhibits should be attached to this statement as an appendix, but list under this item the financial statements and exhibits so attached.

(b) The financial statements shall include the annual financial statements of the ultimate controlling person in the insurance holding company system as of the end of the person's latest fiscal year.

If at the time of the initial registration, the annual financial statements for the latest fiscal year are not available, annual statements for the previous fiscal year may be filed and similar financial information shall be filed for any subsequent period to the extent such information is available. Such financial statements may be prepared on either an individual basis, or unless the Commissioner otherwise requires, on a consolidated basis if such consolidated statements are prepared in the usual course of business.

Unless the Commissioner otherwise permits, the annual financial statements shall be accompanied by the certificate of an independent public accountant to the effect that such statements present fairly the financial position of the ultimate controlling person and the results of its operations for the year ended, in conformity with generally accepted accounting principles or with requirements of insurance or other accounting principles prescribed or permitted under law. If the ultimate controlling person is an insurer which is actively engaged in the business of insurance, the annual financial statements need not be certified, provided they are based on the Annual Statement of such insurer filed with the insurance department of the insurer's domiciliary State and are in accordance with requirements of insurance or other accounting principles prescribed or permitted under the law and regulations of such state.

(c) Exhibits shall include copies of the latest annual reports to shareholders of the ultimate controlling person and proxy material used by the ultimate controlling person, and any additional documents or papers required by Form B or N.J.A.C. 11:1-35.3.

ITEM 9. FORM C REQUIRED

A Form C, Summary of Registration Statement, must be prepared and filed with this Form B.

ITEM 10. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-3, the Registrant has caused this annual registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached annual registration statement dated _____, 19 ____, for and on behalf of _____; that (s)he is the
(Name of Company)

_____ of such company and that (s)he is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

EXHIBIT C

FORM C

SUMMARY OF REGISTRATION STATEMENT

Filed with the Insurance Department of the State of NEW JERSEY

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____

_____

_____

Furnish a brief description of all items in the current annual registration statement which represent changes from the prior year's annual registration statement. The description shall be in a manner as to permit the proper evaluation thereof by the Commissioner, and shall include specific reference to Item numbers in the annual registration statement and to the terms contained therein.

Changes occurring under Item 2 of Form B insofar as changes in the percentage of each class of voting securities held by each affiliate is concerned, need only be included where such changes are ones which result in ownership of holdings of 10 percent or more of voting securities, loss or transfer of control, or acquisition or loss of partnership interest.

Changes occurring under Item 4 of Form B need only be included where: an individual is, for the first time, made a director or executive officer of the ultimate controlling person; a director or executive officer terminates his or her responsibilities with the ultimate controlling person; or in the event an individual is named president of the ultimate controlling person.

If a transaction disclosed on the prior year's annual registration statement has been changed, the nature of such change shall be included. If a transaction disclosed on the prior year's annual registration statement has been effectuated, furnish the mode of completion and any flow of funds between affiliates resulting from the transaction.

The insurer shall furnish a statement that transactions entered into since the filing of the prior year's annual registration statement are not part of a plan or series of like transactions whose purpose it is to avoid statutory threshold amounts and the review that might otherwise occur.

SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-3, the Registrant has caused this summary of registration statement to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19_____.

(SEAL) _____
Name of Registrant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached summary of registration statement dated _____, 19____, for and on behalf of _____; that (s)he is the
(Name of Company)

_____ of such company and that (s)he is authorized to
(Title of Officer)

execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

EXHIBIT D

FORM D

PRIOR NOTICE OF A TRANSACTION

Filed with the Insurance Department of the State of NEW JERSEY

By

_____
Name of Registrant

On Behalf of Following Insurance Companies

Name Address

_____

_____

_____

_____

Date:_____ , 19____

Name, Title, Address and Telephone Number of Individual to Whom Notices and Correspondence Concerning This Statement Should be Addressed:

_____

_____

_____

ITEM 1. IDENTITY OF PARTIES TO TRANSACTION

Furnish the following information for each of the parties to the transaction:

(a) Name.

(b) Home office address.

(c) Principal executive office address.

(d) The organizational structure, that is, corporation, partnership, individual, trust, etc.

(e) A description of the nature of the parties' business operations.

(f) Relationship, if any, of other parties to the transaction to the insurer filing the notice, including any ownership or debtor/creditor interest by any other parties to the transaction in the insurer seeking approval, or by the insurer filing the notice in the affiliated parties.

(g) Where the transaction is with a non-affiliate, the name(s) of the affiliate(s) which will receive, in whole or in substantial part, the proceeds of the transaction.

ITEM 2. DESCRIPTION OF THE TRANSACTION

Furnish the following information for each transaction for which notice is being given:

(a) A statement as to whether notice is being given pursuant to N.J.S.A. 17:27A-4a(2)(a), a(2)(b), a(2)(c), a(2)(d) or a(2)(e).

(b) A statement of the nature of the transaction.

(c) The proposed effective date of the transaction.

ITEM 3. SALES, PURCHASES, EXCHANGES, LOANS, EXTENSIONS OF CREDIT, GUARANTEES OR OTHER CONTINGENT OBLIGATIONS, INVESTMENTS OR LOANS COLLATERALIZED BY THE STOCK OF A SUBSIDIARY OR AFFILIATE

Furnish a brief description of the amount and source of funds, securities, property or other consideration for the sale, purchase, exchange, loan, extension of credit, guarantee or other contingent obligation, investment, or loan collateralized by the stock of a subsidiary or affiliate; whether any provision exists for purchase by the insurer filing notice, by any party to the transaction, or by any affiliate of the insurer filing notice; a description of the terms of any securities being received, if any; and a description of any other agreements relating to the transaction such as contracts or agreements for services, consulting agree-

ments and the like. If the transaction involves other than cash, furnish a description of the consideration, its cost and its fair market value, together with an explanation of the basis for evaluation.

If the transaction involves a loan, extension of credit or a guarantee, furnish a description of the maximum amount which the insurer will be obligated to make available under such loan, extension of credit or guarantee, the date on which the credit or guarantee will terminate, and any provisions for the accrual of or deferral of interest.

If the transaction involves an investment, guarantee or other arrangement, state the time period during which the investment, guarantee or other arrangement will remain in effect, together with any provisions for extensions or renewals of such investments, guarantees or arrangements. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the maximum amount which can at any time be outstanding or for which the insurer can be legally obligated under the loan, extension of credit or guarantee is less than (a) in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, (b) in the case of life insurers, 3 percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 4. LOANS OR EXTENSIONS OF CREDIT TO A NON-AFFILIATE

If the transaction involves a loan or extension of credit to any person who is not an affiliate, furnish a brief description of the agreement or understanding whereby the proceeds of the proposed transaction, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase the assets of, or to make investments in, any affiliate of the insurer making such loans or extensions of credit, and specify in what manner the proceeds are to be used to loan to, extend credit to, purchase assets of, or make investments in, any affiliate. Describe the amount and source of duns, securities, property or other consideration for the loan or extension of credit and, if the transaction is one involving consideration other than cash, a description of its cost and its fair market value together with an explanation of the basis for evaluation. Furnish a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given if the loan or extension of credit is one which equals less than, in the case of non-life insurers, the lesser of 3 percent of the insurer's admitted assets or 25 percent of surplus as regards policyholders or, with respect to life insurers, 3 percent of the insurer's admitted assets, each as of the 31st day of December next preceding.

ITEM 5. REINSURANCE

If the transaction is a reinsurance agreement or modification thereto, as described in N.J.S.A. 17:27A-4a(2)(c), furnish a description of the known and/or estimated amount of liability to be ceded and/or assumed in each calendar year, the period of time during which the agreement will be in effect, and a statement whether an agreement or understanding exists between the insurer and non-affiliate to the effect that any portion of the assets constituting the consideration for the agreement will be transferred to one or more of the insurer's affiliates. Furnish a brief description of the consideration involved in the transaction, and a brief statement as to the effect of the transaction upon the insurer's surplus.

No notice need be given for reinsurance agreements or modifications thereto if the reinsurance premium or a change in the insurer's liabilities in connection with the reinsurance agreement or modification thereto is less than 5 percent of the insurer's surplus as regards policyholders, as of the 31st day of December next preceding.

ITEM 6. MANAGEMENT AGREEMENTS, SERVICE AGREEMENTS AND COST-SHARING ARRANGEMENTS

For management and service agreements, furnish:

(a) A brief description of the managerial responsibilities, or services to be performed.

(b) A brief description of the agreement, including a statement of its duration, together with brief descriptions of the basis for compensation and the terms under which payment or compensation is to be made.

For cost-sharing arrangements, furnish:

(a) A brief description of the purpose of the agreement.

(b) A description of the period of time during which the agreement is to be in effect.

(c) A brief description of each party's expenses or costs covered by the agreement.

(d) A brief description of the accounting basis to be used in calculating each party's costs under the agreement.

ITEM 7. SIGNATURE AND CERTIFICATION

Signature and certification required as follows:

SIGNATURE

Pursuant to the requirements of N.J.S.A. 17:27A-4,

_____ has caused this notice to be duly signed on its behalf in the City of _____ and State of _____ on the _____ day of _____, 19____.

(SEAL) _____
Name of Applicant

BY _____
(Name) (Title)

Attest:

_____
(Signature of Officer)

_____
(Title)

CERTIFICATION

The undersigned deposes and says that (s)he has duly executed the attached notice dated _____, 19____, for and on behalf of _____; that (s)he is the _____ of such
(Name of Company) (Title of Officer)

company and that (s)he is authorized to execute and file such instrument. Deponent further says that (s)he is familiar with such instrument and the contents thereof, and that the facts therein set forth are true to the best of his/her knowledge, information and belief.

(Signature) _____

(Type or print name beneath) _____

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Examination of Insurers

Adopted Concurrent New Rules: N.J.A.C. 11:1-36

Proposed: September 7, 1993 at 25 N.J.R. 4284(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.555, **without change.**

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e) and P.L. 1993, c.236.

Effective Date: October 15, 1993.
Expiration Date: January 31, 1996.

These new rules were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)).

Summary of Public Comments and Agency Responses:

The Department of Insurance (Department) received three written comments from an insurer, an insurance trade association and a law firm representing insurers as follows:

1. Prudential Insurance Company of America;
2. The Reinsurance Association of America; and
3. Hannoch Weisemann.

COMMENT: The commenters suggested that N.J.A.C. 11:1-36.5, which provides procedures for the payment of expenses of an examination by the company examined should contain a mechanism by which a company may challenge the Commissioner's determination of the reasonableness of the examination fees and expenses.

One commenter additionally objected to N.J.A.C. 11:1-36.5(b), which sets forth procedures for the payment of expenses by the company for outside consultants that may be retained by the Commissioner in making an examination of a company pursuant to P.L. 1993, c.245, section 4d. The commenter stated that the rule provides for unilateral approval by the Commissioner of the expenses of outside consultants. The commenter expressed concern that companies will have no input into the fees of outside consultants. The commenter thus suggested that the rule be revised either to provide that the fees will be mutually agreed upon by the company and the Commissioner, or to provide a mechanism to appeal the Commissioner's determination of the reasonableness of such fees as described above.

RESPONSE: Upon review of the commenters' suggestions, the Department has determined not to change this provision. The Department initially notes that N.J.A.C. 11:1-36.5 does not establish new procedures, but rather codifies existing Department practices, consistent with P.L. 1993, c.236, sections 3d and 4d. These statutory provisions reflect prior statutory authority and Department practice regarding the payment of examination expenses. The Department therefore does not believe any additional "appeal mechanism" is necessary. The appeal mechanism would be the same as that currently utilized for disputes regarding examination fees (that is, appeal to the Appellate Division of the Superior Court).

The Department further believes that it would be inappropriate to require that a company agree to the fees for consultants. Such a provision would effectively give a company "veto power" over a consultant that the Commissioner seeks to retain, contrary to the provisions of P.L. 1993, c.236, section 4d. The Department notes that, to date, it is not aware of any problems cited by the companies regarding the use of consultants by the Commissioner.

Finally, the Department notes that it is Commissioner's responsiblity both to determine and to protect the solvency of a company. It would be contrary to that purpose and responsibility to authorize or approve fees for examinations which are not reasonable or which do not reflect the costs of making the examination required pursuant to P.L. 1993, c.236.

COMMENT: One commenter expressed concern with N.J.A.C. 11:1-36.3, which provides procedures for determining when a "comprehensive" or "financial condition" examination is deemed "complete." The commenter noted that the Department stated in the proposal Summary that it interprets section 5 of P.L. 1993, c.236, governing the process and procedures for the adoption of examination reports, to apply only to reports containing findings resulting from a comprehensive examination of the insurer. The commenter stated that this interpretation inappropriately excludes "market conduct" examinations. The commenter believes that since the statute permits the Commissioner to examine the insurer's "method of conducting business" (that is, market conduct), it would be inappropriate to provide that section 5 of the statute, governing adoption of examination reports, does not apply to reports of market conduct examinations. The commenter recognized that it may be appropriate to provide a different definition of "complete" for market conduct examinations, but believed that this issue should not be left "open ended." Finally, the commenter stated that three of the insurers it represents are awaiting the results of market conduct examinations performed by the Department in 1990.

RESPONSE: The Department recognizes and agrees that it is necessary to provide a process for determining when a market conduct examination shall be deemed "complete." However, through discussions with the National Association of Insurance Commissioners (NAIC), it is the Department's understanding that the procedures for adopting examination reports set forth in P.L. 1993, c.236 generally relate to financial condition examinations because these examinations are generally relied upon and adopted by other states. For example, a major provision of the examination statute, as well as the entire NAIC accreditation program, is the general prohibition against accepting examinations conducted by the insurer's state of domicile unless that insurance department was accredited by the NAIC at the time the examination was conducted. This provision has application only in the case of financial condition examinations since market conduct examinations are not adopted by other states and generally focus on business activities of an insurer within a particular state. Even the commenter stated that time frames for determining when market conduct examinations are deemed complete may be different from that for financial condition examinations. In consideration of the necessity to promptly adopt rules for NAIC accreditation, the Department has limited the scope of the rules to the process for determining when financial examinations shall be deemed complete. The Department will promulgate regulations to address market conduct examinations in the future.

Also, the Department notes that its records indicate that the final report of the market conduct examinations of the insurers in question were filed in July, 1991 and April, 1992.

Full text of the adopted new rules follows:

SUBCHAPTER 36. EXAMINATION OF INSURERS

11:1-36.1 Purpose and scope

(a) This subchapter sets forth certain procedures and processes for the examination of the financial condition of a company and for the payment of expenses of any examination conducted pursuant to P.L.1993, c.236.

(b) This subchapter applies to all insurers licensed to transact insurance in this State and to any company or person subject to examination by the Commissioner pursuant to P.L.1993, c.236.

11:1-36.2 Definitions

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

"Alien insurer" means an insurer formed under the laws of any country other than the United States, its states, districts, territories, commonwealths and possessions.

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

"Company" means any insurer or other person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the Commissioner.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of this State.

"Examiner" means any individual or firm authorized by the Commissioner to conduct an examination pursuant to P.L.1993, c.236.

"Financial condition examination" means a comprehensive examination of the assets and liabilities, method of conducting business and all other affairs of any company which is the subject matter of the examination report filed pursuant to the procedures set forth in P.L.1993, c.236 and this subchapter.

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

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer or other person engaged in the business of insurance pursuant to Subtitle 3 of the Title 17 of the Revised Statutes or Subtitle 3 of the Title 17B of the New Jersey Statutes.

"Joint examination" means the examination of affiliated insurers that have any type of interinsurance, reinsurance, or other business dealings, and of insurers that have, through reinsurance affiliations, provided 35 percent or more of the existing surplus support at the as-of-date of the examination.

"Lead state" means the state where the parent insurer is domiciled or, if there is no insurer parent, the state where the largest (by direct written premium volume as shown by the last filed annual statement) insurer subsidiary is domiciled.

"NAIC" means the National Association of Insurance Commissioners.

11:1-36.3 Examination; when deemed complete

(a) For purposes of P.L.1993, c.236, section 5b, an examination of the financial condition of a company shall be deemed complete not later than 90 days after the date the examiner leaves the site of the company, or not later than 90 days after the date the company responds to the last written request from the examiner(s) for ad-

ditional information, but in no event later than 180 days after the date the examiner leaves the site of the company provided that the company has responded to any written request for additional information made 90 days or more prior to that date. For good cause, the Chief Insurance Examiner of the Department may extend these time frames for an additional period of time not to exceed 90 days.

(b) A company shall provide any additional information, documentation or other data requested by an examiner not later than 30 days after such request.

(c) In the case of joint examinations, the time frames set forth in (a) above shall apply where this State is the lead state conducting such joint examination. Where this State is not the lead state, the time frames set forth in (a) above may apply with the agreement of the lead State.

11:1-36.4 Foreign and alien insurers; filing of examination reports with this State

(a) A foreign or alien insurer licensed to transact business in this State shall file with the Department a copy of the financial condition examination report prepared by the insurance department or other regulatory agency for the insurer's state of domicile or port-of-entry state.

1. The copy of the examination report shall be filed not later than 180 days after the report is adopted by the insurance department or regulatory agency of the insurer's state of domicile or port-of-entry state, and shall be certified by such department or agency as representing a true and accurate report of the examination conducted by its duly appointed examiner in charge who satisfies the minimum qualifications to be the examiner in charge of such examination as set forth in the Examiners' Handbook adopted by the NAIC as in effect at the time such examination was conducted.

2. After January 1, 1994, in addition to the requirements set forth in (a) and (a)1 above, the insurer shall provide a certification from the insurance department or regulatory agency that:

i. The insurance department or regulatory agency was at the time of the examination accredited under the NAIC's Financial Regulation Standards and Accreditation Program; or

ii. The examination was performed under the supervision of an accredited insurance department or other regulatory agency or with the participation of one or more examiners who are employed by such an accredited state insurance department or other regulatory agency who satisfy the minimum qualifications to be an examiner as set forth in the Examiners' Handbook adopted by the NAIC as in effect at the time the examination was conducted and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department or other regulatory agency.

11:1-36.5 Payment of expenses

(a) Pursuant to P.L.1993, c.236, section 3d, the reasonable expenses of any examination and proceedings conducted under that statute shall be fixed and determined by the Commissioner, and he or she shall collect them from the company examined, which shall pay them on a presentation of an account of expenses. Any and all such receipts shall be appropriated to the Department for use in defraying the expenses of such examination. If any company, after examination, is adjudged insolvent by a court of competent jurisdiction, the expense of the examination, if unpaid, shall be ordered out of the assets of the company.

(b) Pursuant to P.L.1993, c.236, section 4d, the Commissioner may, in making an examination under that statute, retain attorneys, appraisers, independent actuaries, independent certified public accountants, or other professionals as examiners, the cost of which shall be borne by the company being examined. Upon presentation of a detailed invoice for such fees and expenses, and upon review and approval by the Commissioner of the adequacy and reasonableness of such fees and expenses, the Commissioner shall authorize and direct that the company pay such amount directly to the third party retained by the Commissioner to assist in the examination. The company shall make such payment within 30 days of the Commissioner's approval of the adequacy and reasonableness of such fees and expenses.

11:1-36.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as authorized by law.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Determination of Insurers in a Hazardous Financial Condition

Adopted Concurrent New Rule and Amendments: N.J.A.C. 11:2-27

Proposed: September 7, 1993 at 25 N.J.R. 4286(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.556, **with substantive changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:23-1 et seq., 17B:21-1 et seq., 17:27A-1 et seq., 17:30C-1 et seq., 17B:32-31 et seq., P.L. 1993, c.234, P.L. 1993, c.235 and P.L. 1993, c.245.

Effective Date: October 15, 1993, Readoption of emergency new rule and amendments;
November 15, 1993, Changes upon adoption.
Expiration Date: November 30, 1995.

These amendments and new rule were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed rule and amendments is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for changes upon adoption, which are effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

The Department of Insurance (Department) received two written comments from an insurer and an insurer trade association as follows:

1. Prudential Insurance Company of America; and
2. The American Insurance Association.

COMMENT: One commenter expressed concern with N.J.A.C. 11:2-27.4(b), which requires that an insurer objecting to an order issued by the Commissioner pursuant to the rules file a statement specifying why the order would not result in improving the condition of the insurer. The commenter stated that if the insurer objects to the Commissioner's threshold determination that it is in a hazardous financial condition, the required statement is inappropriate and immaterial. The commenter thus suggested that this provision be modified.

RESPONSE: The Department disagrees. If the Commissioner finds that an insurer's condition renders the continuance of its business hazardous to the public or its insureds, the Commissioner may place the insurer under administrative supervision pursuant to P.L. 1993, c.245, and issue a "corrective action order" which requires the insurer to take steps to abate that determination. The insurer may request a hearing if it objects to the actions ordered to be taken. In specifying the reasons for its objection, an insurer may assert that the corrective actions to be taken will not improve its condition because it is not in a hazardous financial condition, and therefore no corrective action is warranted. The Department thus does not believe that this requirement in N.J.A.C. 11:2-27.4(b)1iv is immaterial or inappropriate. The rule merely requires that the insurer specify the reasons and justifications for its objections to define the scope of the issues to be resolved at the hearing pursuant to N.J.A.C. 1:1.

COMMENT: One commenter stated that N.J.A.C. 11:2-27.1(a), which provides in pertinent part that a finding of hazardous financial condition provides one of the grounds "upon which the Commissioner may seek an order from the Superior Court to rehabilitate, liquidate or conserve the assets" of an insurer, is inconsistent with the underlying statutory provision. The commenter stated that the relevant statute provides that such steps may be taken only "upon examination," and believes that the

rules should contain the same limitation as the underlying statute. The commenter therefore suggested that the rules be modified to include the phrase "upon examination."

RESPONSE: Upon review of the commenter's suggestion, the Department has determined that no change is required. The Department initially notes that the relevant portion of N.J.A.C. 11:2-27.1(a) to which the commenter refers was not amended. Therefore, the comment is outside the scope of the proposal. The Department also notes that the phrase "upon examination" is contained in N.J.S.A. 17:30C-6f (relating to property/casualty insurers), but is not contained in the corresponding statute at N.J.S.A. 17B:32-41a (relating to life/health insurers).

Moreover, the Department does not believe that the rules expand the Commissioner's statutory authority regarding the rehabilitation or liquidation of insurers in that such action taken by the Commissioner would conform with the requirements set forth in N.J.S.A. 17:30C-1 et seq. or 17B:32-31 et seq., as applicable.

Finally, the Department believes that no additional clarification is required in any case in that any finding of hazardous financial condition would be made after an examination of the insurer. The Department notes however that the term "examination" as used in N.J.S.A. 17:30C-6f is not defined. The Department consistently has not interpreted that statute to require the finding be made only after a comprehensive "on-site" examination of the insurer. Rather, such a finding may be made upon preliminary findings from a comprehensive examination, upon the examination of the insurer's annual statement, or upon examination of any other information filed by the insurer or obtained by the Commissioner from other sources.

Summary of Agency-Initiated Change

N.J.A.C. 11:2-27.4(b)3, which provides for making hearings public, is revised to ensure consistency and uniformity with the statutory language set forth in P.L. 1993, c.245, sections 4c and 4d, 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.

Full text of the adopted new rules follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 27. DETERMINATION OF INSURERS IN A HAZARDOUS FINANCIAL CONDITION

11:2-27.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the factors which the Commissioner shall consider in determining whether an insurer is in a hazardous financial condition as defined herein. A determination of hazardous financial condition provides one of the grounds upon which the Commissioner may seek an order from the Superior Court to rehabilitate, liquidate the business or conserve the assets within this State of domestic, foreign or alien insurers pursuant to N.J.S.A. 17:30C-1 et seq. and 17B:32-31 et seq., or upon which an insurer may become subject to administrative supervision pursuant to P.L. 1993, c.245, and provides one of the grounds upon which the Commissioner may take action to revoke or nonrenew an insurer's authority to transact insurance in this State, or withdraw the eligibility of an eligible surplus lines insurer to insure surplus lines risks in the State pursuant to law, including, but not limited to, N.J.S.A. 17:32-2, 17B:23-2, and 17:22-6.46.

(b) This subchapter shall apply to all domestic, foreign and alien insurers and all other entities subject to N.J.S.A. 17:30C-1 et seq., 17B:32-31 et seq., or P.L. 1933, c.245; and to all eligible surplus lines insurers.

11:2-27.2 Definitions

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

"AVR" means the asset valuation reserve calculated for purposes of completing the NAIC annual statement in accordance with its instructions and Accounting Practices and Procedures Manual.

. . .

"Insurer" means a person subject to the insurance supervisory authority of, or to liquidation, rehabilitation, reorganization, or conservation by, the Commissioner pursuant to N.J.S.A. 17:30C-1 et seq., 17B:32-31 et seq. or P.L. 1993, c.245, or by the equivalent insurance supervisory official of another state. "Insurer" includes all persons purporting to be engaged in the business of insurance as an insurer in this State and all persons in the process of organization to become insurers.

. . .

11:2-27.3 Determination of hazardous financial condition; factors

(a) The Commissioner shall consider the following factors, either singly or in a combination of two or more, in determining whether an insurer is in a hazardous financial condition:

1.-16. (No change.)

17. A finding that a life insurer's surplus as regards policyholders plus AVR reserves is not adequate in relation to the amount of liabilities less AVR reserves less separate account liabilities;

18. A finding that the insurer does not possess the minimum capital and surplus (in the case of stock insurers) or net assets (in the case of mutual insurers) required by statute to be maintained or as otherwise required by the Commissioner pursuant to law;

Recodify existing 18. through 28. as 19. through 29. (No change in text.)

(b) (No change.)

11:2-27.4 Determination of hazardous financial condition; corrective action

(a) If the Commissioner determines that the continued operation of an insurer may be hazardous to the policyholders or public in this State, the Commissioner may, upon such a determination, subject the insurer to administrative supervision pursuant to P.L. 1993, c.245 and may issue an order requiring the insurer to take such actions as the Commissioner deems necessary to abate such determination, including, but not limited to:

1. Reduce the total amount of present and potential liability for policy benefits by reinsurance;

2. Reduce, suspend or limit the volume of business being accepted or renewed;

3. Reduce general insurance and commission expenses by specified methods;

4. Increase the insurer's capital and surplus;

5. Suspend or limit the declaration and payment of dividends by an insurer to its stockholders or to its policyholders;

6. File reports in a form acceptable to the Commissioner concerning the market value of an insurer's assets;

7. Limit or withdraw from certain investments or discontinue certain investment practices to the extent the Commissioner deems necessary;

8. Document the adequacy of premium rates in relation to the risks insured;

9. File, in addition to regular annual statements, interim financial reports on the form adopted by the NAIC or in such format as prescribed by the Commissioner; or

10. Take such other actions as the Commissioner may deem necessary in a particular case to protect the insurer's policyholders and the public.

(b) If an insurer is subject to an order issued by the Commissioner pursuant to (a) above, and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing before the Department on the Commissioner's determination within 10 days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the manner wherein the action(s) ordered by the Commissioner would not result in improving the condition of the insurer.

2. Pursuant to P.L. 1993, c.245, all proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the Commissioner or the Department relating to the supervision of the insurer are confidential, except as otherwise provided by P.L. 1993, c.245. Any confidential proceedings in connection with an order issued pursuant to this rule and P.L. 1993,

c.245 shall be held by the Commissioner or his designee at the Department.

3. *[If the Commissioner opens such proceedings or hearings to the public pursuant to P.L. 1993, c.245, he may transmit the matter to the Office of Administrative Law for further proceedings in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. and Uniform Administrative Procedure Rules, N.J.A.C. 1:1.]* ***The Commissioner may open such proceedings or hearings or disclose the notices, correspondence, reports, records or information to a department, agency or instrumentality of this or another state of the United States, or make such information public, if the Commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States, is in the best interest of the public, or in the best interest of the insurer, its insureds or creditors.***

(c) Nothing contained in this section shall be construed to limit or preclude the Commissioner from independently requiring an insurer to take specific actions or limit specified activities pursuant to other provisions of Title 17 or 17B of the Revised Statutes.

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Credit for Reinsurance

Adopted Concurrent New Rules: N.J.A.C. 11:2-28

Proposed: September 7, 1993 at 25 N.J.R. 4289(a).

Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: October 15, 1993 as R.1993 d.557, **with substantive and technical changes** not requiring additional public comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e) and P.L. 1993 c.243 (enacted August 9, 1993).

Effective Date: October 15, 1993, Readoption of emergency new rules and amendments;
November 15, 1993, Changes upon adoption.

Expiration Date: November 30, 1995.

These rules were adopted on an emergency basis on August 16, 1993 and concurrently reproposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). This present adoption of the concurrent reproposed new rules is effective upon acceptance for filing by the Office of Administrative Law (see N.J.A.C. 1:30-4.4(e)) except for changes on adoption which are effective on November 15, 1993, the date of publication of this notice.

Summary of Public Comments and Agency Responses:

The adopted emergency new rules were published on September 7, 1993 at 25 N.J.R. 4289(a). During the comment period which closed October 7, 1993, five comments were submitted from an insurance company (Prudential Insurance Company of America), trade associations (Alliance of American Insurers and Reinsurance Association of America), a reinsurer intermediary-broker (Guy Carpenter & Company, Inc.) and counsel to ceding insurers and reinsurers (LeBoeuf, Lamb, Leiby and MacRae).

These comments and the Department's responses are summarized below:

COMMENT: One commenter opposed this State's rules on credit for reinsurance claiming that the subchapter imposes stricter standards than those set forth in the NAIC model rules. The commenter also asserted that because of New Jersey's stricter standards, it is possible that no states, including NAIC accredited states, will be considered to have substantially similar rules governing credit for reinsurance. The commenter also claimed that making it harder for reinsurers to qualify for reinsurance credit purposes in New Jersey puts New Jersey domestics at a competitive disadvantage to ceding companies licensed and domiciled in other states that do not have as restrictive requirements.

The commenter also opined that reinsurers who are domiciled in other states should not be required to make additional filings in New Jersey nor should they be required to pay filing fees in this State.

RESPONSE: The standards set forth in this subchapter are required by P.L. 1993, c.243 and are intended to enable the Department to determine whether a reinsurer is financially sound and, therefore, qualified to provide reinsurance. This new subchapter, which codifies many of New Jersey's current practices, also expands the market of reinsurers from which ceding insurers may obtain reinsurance and still be eligible for a credit for such insurance ceded. This subchapter provides the same categories of acceptable reinsurers as those set forth in the NAIC rules.

The Department does not view this State's standards as being more strict than those set forth in the NAIC model rules. The Department expects that all states will use criteria similar to that contained in this subchapter in order to determine whether a reinsurer is financially sound. This State may require the filing of more detailed information from reinsurers doing business in New Jersey. However, the information is required in order to streamline the Department's review process of those reinsurers which are not domiciled in New Jersey.

The Department anticipates that the states which have adopted the NAIC model rules and/or are accredited by the NAIC, will have substantially similar rules regarding credit for reinsurance as those of this State.

The filing fees which are required from reinsurers doing business in New Jersey are reflective of the work which has been and will be required by the Department to implement this subchapter.

COMMENT: One commenter expressed its concern with regard to foreign insurers authorized to transact business in New Jersey which are domiciled in states whose regulations on credit for reinsurance are below this State's standards in that such ceding insurers may be exposed to inconsistent state action.

RESPONSE: No change in these rules is required. P.L. 1993, c.243 requires that any foreign ceding insurer domiciled in a state whose standards are not substantially similar to New Jersey's rules shall conform to this State's rules to be eligible for a credit for reinsurance ceded. Conversely, any insurer which is domiciled in a state with substantially similar laws or which is accredited by the NAIC shall be governed by the laws of its state of domicile.

COMMENT: One commenter suggested that this proposal is flawed with regard to overseas surplus lines insurers because the Commissioner will be required to expend great effort in analyzing the laws of other countries to determine if their regulations are substantially similar to those of New Jersey. Moreover, the commenter suggested that it is unrealistic to expect alien insurers and reinsurers to adjust their trade relationships to comply with New Jersey law particularly where they may not reinsure United States cedents. The commenter further indicated that this subchapter may present serious trade implications if the Commissioner were to grant one country "favored status."

RESPONSE: The Department notes that this subchapter has been promulgated in accordance with P.L. 1993, c.243. As a result, no changes are necessary in the Department's treatment of alien reinsurers. Moreover, the commenter has not suggested what type of changes it believes may be appropriate.

This commenter has only focused on the section which permits a credit for reinsurance ceded to reinsurers with substantially similar laws to those of this State. It is noted, however, that a reinsurer has a number of alternatives in order to qualify as a reinsurer in New Jersey, so that a ceding insurer may obtain credit for its cessions to the reinsurer. One such alternative is maintaining trust funds in a qualified United States financial institution.

COMMENT: One commenter suggested that the scope of the rules as set forth at N.J.A.C. 11:2-28.1(b) should be amended to eliminate any confusion as to which insurers these rules apply. The commenter suggested that the scope of the rules may be interpreted to require ceding reinsurers which are domiciled in a state which utilizes substantially similar laws, to comply with this subchapter. The commenter recommended that the language be amended to read:

"This subchapter applies to all insurers which transact business in this State, **except as described in (b)2 below.**"

RESPONSE: The Department notes that the commenter's suggestion is consistent with the intent of this subchapter and amends the section accordingly for purposes of clarity.

COMMENT: One commenter noted that the term "authorized officer" is defined as "the president of the company" and that unincorporated underwriters do not have a "president" as contemplated by the definition.

RESPONSE: While the definition specifically states alternatives to the named officers by including "any such equivalent officers," the Depart-

ment has amended this section to clarify the intent of the proposal that unincorporated underwriters may be structurally different. The definition is, therefore, amended to read ". . . any such equivalent officers **or individuals**."

COMMENT: One commenter suggested that the definition of "beneficiary" should include both a domestic and an ancillary receiver so as not to conflict with the laws of other states.

RESPONSE: The Department does not believe that any change is necessary because the definition was incorporated from the language set forth in the NAIC model rules.

COMMENT: Another commenter recommended that the term "beneficiary" be amended to read ". . . the entity for whose **sole** benefit the trust has been established . . ." as set forth in the NAIC model rules.

RESPONSE: The Department agrees with the suggestion and amends the definition for purposes of clarity.

COMMENT: One commenter suggested that the term "grantor" be amended to read ". . . the entity that has established a trust for the **sole** benefit of the beneficiary," as set forth in the NAIC model rules.

RESPONSE: The Department agrees with the suggestion and amends the definition for purposes of clarity.

COMMENT: A commenter suggested that the definition of "insurer" is too broad and may imply that certain excess of loss or stop loss agreements are reinsurance transactions.

RESPONSE: Excess of loss or stop loss agreements may involve primary insurance rather than reinsurance; for example, where an entity is self-insured. The definition of reinsurance set forth in this subchapter clarifies that such forms of primary insurance arrangements are not considered reinsurance transactions. The Department, therefore, believes that a change in the definition of "insurer" is unnecessary.

COMMENT: One commenter suggested that the definition of "ceding insurer" be amended to include language which purports to clarify that ceding insurers domiciled in another state which employ substantially similar standards on credit for reinsurance as those in this State are governed by the standards of their own state. The commenter also recommended that certain sections should be amended to read "**ceding** insurer . . . which . . . cedes . . ."

RESPONSE: The Department disagrees with this commenter's recommendations. The scope of the rules is set forth at N.J.A.C. 11:2-28.2 and adequately addresses the concerns of this commenter. Therefore, the language suggested by the commenter need not be repeated in the definition of "ceding insurer." The recommendation to include "ceding insurer . . . which cedes" is redundant and unnecessary.

COMMENT: A commenter suggested deleting the definitions of "reinsurance intermediary-broker" and "reinsurance intermediary-manager" because the terms do not appear in the subchapter.

RESPONSE: The Department disagrees with this recommendation because the terms appear in the definition of "reinsurance intermediary" which is used in this subchapter.

COMMENT: One commenter inquired whether credit would be disallowed if a reinsurer that either lost or was denied accredited status provided a letter of credit or trust agreement as collateral for its obligations to the cedent.

RESPONSE: The commenter has not provided specific reasons in its hypothetical question which would clarify the circumstances for which the reinsurer either lost or was denied accredited status. The rules, however, provide several alternative means of qualifying for credit for reinsurance. If such a reinsurer is not qualified under one alternative, it may nevertheless qualify under another alternative. Again this would be dependent upon the reasons for the denial or revocation of accredited status.

COMMENT: One commenter suggested that N.J.A.C. 11:2-28.4(a)6 should be amended to read as follows:

6. Either:

i. Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the Commissioner within 120 days of filings its submission with the Commissioner, or, {in the case of reinsurers with}

ii. Maintains a surplus as regards policyholders of less than $20,000,000 whose accreditation has been approved by the Commissioner; and. . . .

RESPONSE: This suggested change in the codification may promote clarity and has, therefore, been included in the adoption.

COMMENT: One commenter suggested that N.J.A.C. 11:2-28.4(a)6 which grants an applicant accredited status if its filing with the Commissioner is not denied within 120 days, is at odds with subsections (c) through (e). The commenter suggested that the 120 day reference should be deleted from N.J.A.C. 11:2-28.4(a)6 and a reference should be made to subsections (c) through (e) for consistency.

RESPONSE: In order to be consistent with the statute and to clarify that prior approval is necessary for applicants whose surplus as regards policyholders is less than $20,000,000, the Department amends N.J.A.C. 11:2-28.4(c) to include the following language:

"Except for applicants for accreditation that maintain surplus as regards policyholders of less than $20,000,000. . .".

COMMENT: One commenter suggested that the meaning of N.J.A.C. 11:2-28.4(a)7 and (f)1 through 5 should be clarified.

RESPONSE: No changes to these sections are necessary. N.J.A.C. 11:2-28.4(a)7 permits the Commissioner to request specific information regarding a particular reinsurer's application for accreditation. N.J.A.C. 11:2-28.4(f)1 through 5 require insurers to report certain actions by other states or jurisdictions that may indicate a substantial change in their financial conditions.

COMMENT: Several commenters suggested that the requirement at N.J.A.C. 11:2-28.5(a)5ii that loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio, may cause underreserving and that the risk based capital requirements would be a better gauge.

RESPONSE: The Department agrees that risk based capital requirements may be an appropriate gauge. However, model property/casualty risk based capital rules have not yet been adopted by the NAIC. The Department is, therefore, adopting its current standard in this subchapter.

COMMENT: A commenter stated that N.J.A.C. 11:2-28.6(a)8 is unclear as to whether an actuarial certification must be given on the adequacy of all of the reinsurer's liabilities or only those that relate to the trusteed business.

RESPONSE: The rule states that the opinion is necessary "in order to determine the sufficiency of the trust fund." Since the trust is intended to cover obligations in the United States, an actuarial opinion relating to the trusteed business is necessary. The Department notes that it may also require additional information in appropriate circumstances, pursuant to this section.

COMMENT: One commenter claimed that the concept of "surplus as to policyholders" set forth at N.J.A.C. 11:2-28.6(a)2iv(2) does not apply to unincorporated associations, that the ratio may be too conservative and suggested "greater regulatory flexibility" in the section.

RESPONSE: The Department believes that the 3:1 ratio is a reasonable standard to assure that the assuming insurer is not in a hazardous financial condition such that credit for reinsurance may be granted. The Department is not willing to change this standard on adoption for certain reinsurers in the absence of a satisfactory alternative provision. The commenter has suggested none.

The Department acknowledges this difficulty for unincorporated associations and the difficulties with respect to filing a report with substantially the same information as that required on the NAIC annual statement, which includes "surplus as to policyholders." The Department would consider appropriate amendments to address the problems of these entities.

COMMENT: One commenter noted that overseas reinsurers prepare their annual reports in accordance with the requirements of their domestic regulators and would, therefore, be unable to satisfy the June 1 filing deadline set forth at N.J.A.C. 11:2-28.6(a)4. It also stated that an unincorporated association would be able to supply the substantial equivalent of a loss reserve adequacy opinion required in accordance with N.J.A.C. 11:2-28.6(a)8.

RESPONSE: The Department notes that a reinsurer's most recent information shall be filed in order to comply with the June 1 filing date set forth at N.J.A.C. 11:2-28.6(a). N.J.A.C. 11:2-28.6(8) specifically states that a reinsurer shall report "substantially" the same information as that to be reported on the NAIC annual statement form. Thus, an actuarial opinion which certifies to the adequacy of loss and loss adjustment expense reserves is necessary although its form may differ from the NAIC standard format.

COMMENT: Several commenters suggested modifications to N.J.A.C. 11:2-28.6(b) including that N.J.A.C. 11:2-28.6(b)2 be changed to reflect an amendment to P.L. 1993, c.243 affecting unincorporated underwriters. One commenter proposed the following language:

The trust fund for a group of insurers, which group includes individual unincorporated underwriters, . . . The group shall make available to the

Commissioner an annual certification of the solvency of each underwriter **and each insurer** for the fiscal period immediately preceding ...

The commenter also recommended revisions to N.J.A.C. 11:2-28.6(b)1 and 2 to track the language in (b)3 by incorporating the language "in an amount not less than."

RESPONSE: The Department agrees with the recommendation to amend N.J.A.C. 11:2-28.6(b)1 and 2 to track the language in (b)3 and has revised the sections accordingly. However, P.L. 1993, c.243 does not require the addition of "and each insurer" to N.J.A.C. 11:2-28.6(b)2. Therefore, this change has not been incorporated.

COMMENT: A commenter claimed that the acceptable assets for trust funds as set forth at N.J.A.C. 11:2-28.6(c)5i may be too narrow. For example, certain unincorporated association trust funds include mortgage backed securities which are not SVO listed because they are privately placed.

RESPONSE: Any securities which are contained in a trust fund must be readily valuable by the Department. The list of assets set forth at N.J.A.C. 11:2-28.6(c)5i include just such assets. Mortgage backed securities cannot be readily valued.

COMMENT: One commenter inquired whether letters of credit could be used to fund a trust required by N.J.A.C. 11:2-28.8(b).

RESPONSE: Letters of credit may be used, but only if they meet the requirements set forth at N.J.A.C. 11:2-28.10 regarding letters of credit.

COMMENT: One commenter recommended that N.J.A.C. 11:2-28.7(b) should be amended to delete the term "domestic" insurer and substitute the term "ceding" insurer.

RESPONSE: The Department concurs with this recommendation and amends the section accordingly to clarify the intent of the proposal.

COMMENT: One commenter noted that N.J.A.C. 11:2-28.8, which is based on the NAIC model rules, has made certain provisions mandatory rather than permissive, as in the model rules. The commenter suggested that this section should be amended to conform with the exact language of the model rules.

RESPONSE: The Department disagrees. The Department believes that it has properly chosen to make certain provisions mandatory rather than permissive in order to provide proper standards. For the most part any departures from the language contained in the NAIC model rules were undertaken merely to conform the NAIC model to New Jersey administrative rule codification procedures.

COMMENT: Several commenters suggested that N.J.A.C. 11:2-28.9(c)3i should be amended to delete the reference that a reinsurance intermediary is a fiduciary. The commenter stated that the intermediary is not a party to the contract and would, therefore, not be bound by the terms of the contract. The commenter suggested that the responsibilities of an intermediary should be addressed in the rules on reinsurance intermediaries.

RESPONSE: The Department concurs with the suggestion for the reasons stated by the commenters and has, therefore, deleted the language.

COMMENT: A commenter suggested that N.J.A.C. 11:2-28.9(a)5 be amended to read: "The trust agreement shall be established for the **sole** benefit of the beneficiary."

RESPONSE: The Department concurs with the suggestion and amends the provision accordingly for the reasons stated above with regard to a prior comment.

COMMENT: One commenter suggested that N.J.A.C. 11:2-28.9(a)2 and (b)1 and 2, for purposes of clarity, should track the NAIC model rules verbatim.

RESPONSE: The Department believes that these sections are clear and do not require any change and essentially do track the model verbatim.

COMMENT: Several commenters stated that N.J.A.C. 11:2-28.12 is redundant and inconsistent. Commenters have also criticized the provision as drafted, stating that: the section attempts to circumvent the jurisdiction of the state of domicile in ceding insurer solvency matters; that N.J.A.C. 11:2-28.12(a)1 implies that the Commissioner's approval is required before an alternate payee clause may be employed and enforced; and that the intent and manner in which to implement N.J.A.C. 11:2-28.12(a)1 and (b)1 and 2 are unclear.

RESPONSE: The Department agrees that N.J.A.C. 11:2-28.12 should be reorganized for clarity and has revised this provision by combining subsections (a) and (b) and eliminating the duplication in the two subsections. The Department disagrees with the contention that this section subverts the jurisdiction of the state of domicile of the ceding insurer because if the ceding insurer is declared insolvent, the liquidation statute of its state of domicile will govern. Moreover, this section does not contain a blanket prohibition on alternate payees but merely provides that where the ceding insurer has been declared insolvent the reinsurer may not reduce the amount of reinsurance payable to such insurer because of its insolvency and must remit the reinsurance proceeds to the receiver of the insurer.

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

SUBCHAPTER 28. CREDIT FOR REINSURANCE

11:2-28.1 Purpose and scope

(a) The purpose of these rules is to implement the provisions of P.L. 1993, c.243 by establishing procedures to be employed by insurers which cede risks to appropriate reinsurers and which assume the risk from the ceding insurers to whom these rules apply.

(b) This subchapter applies to all insurers which transact business in this State, ***except as described in (b)2 below,*** including insurers which are domiciled in this State. This subchapter also applies to insurers which are either licensed to transact business in this State or are eligible to write surplus lines insurance in this State, and which in either case are domiciled in a state or country which does not employ standards regarding credit for reinsurance substantially similar to the standards set forth herein.

1. For a life and health ceding insurer to qualify for a credit for reinsurance in accordance with this subchapter, the ceding insurer shall also comply with the requirements of P.L. 1993, c.243 and all administrative rules promulgated thereunder concerning the regulation of life and health reinsurance contracts.

2. Where an insurer which is either licensed to transact business in this State or is an eligible surplus lines insurer in this State and in either case the state in which it is domiciled is accredited by the NAIC or employs standards regarding credit for reinsurance as determined by the Commissioner to be substantially similar to the standards set forth in these rules, the insurer shall comply with the rules regarding credit for reinsurance in its state of domicile.

11:2-28.2 Definitions

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

"Annual statement" means a statement showing an insurer's financial condition at the close of business on December 31 of the preceding year and its business for that year in the form adopted by the NAIC, prepared in accordance with the annual statement instructions and the Accounting Practices and Procedures Manual adopted by the NAIC and all applicable provisions of law.

"Assuming insurer" or "reinsurer" means any person which engages in the activity of insuring part or all of an insurance risk from an originating or ceding insurer.

"Authorized officer" means the president of the company whose signature is attested to by the secretary of the company or any such equivalent officers ***or individuals***.

"Beneficiary" as used in connection with the establishment of a trust agreement means the entity for whose ***sole*** benefit the trust has been established and any successor of the beneficiary by operation of law. Where a court of competent jurisdiction appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

"Ceding insurer" means an insurer which procures indemnification for itself from an assuming insurer with respect to all or part of an insurance risk associated with one or more policies which it issued should losses be sustained.

"Certificate of eligibility" means a certificate issued by the Commissioner evidencing the authority of an unauthorized insurer to transact the business of surplus lines insurance in this State.

"Clean and unconditional letter of credit" or "clean and unconditional confirmation" means a letter of credit or confirmation which:

1. Makes no reference to any other agreement, document or entity;

2. Provides that a beneficiary need only draw a sight draft under the letter of credit or confirmation and present it to promptly obtain funds and that no other document need be presented; and

3. Indicates that it is not subject to any conditions or qualifications outside of the letter of credit.

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

"Date of the ceding insurer's statutory financial statement" means the period ending date for which the statutory financial statement is rendered.

"Delinquency proceeding" means, for the purpose of this subchapter, any proceeding commenced against a reinsurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such reinsurer.

"Department" means the New Jersey Department of Insurance.

"Domestic insurer" means an insurer formed under the laws of the State of New Jersey.

"Eligible surplus lines insurer" means an unauthorized insurer which is issued a certificate of eligibility to transact the business of insurance in this State and in which insurance coverage is placed or may be placed pursuant to N.J.S.A. 17:22-6.40 et seq.

"Evergreen" means a provision in a letter of credit or its confirmation which prevents the expiration of the letter of credit or its confirmation without due advance written notice to the beneficiary from the issuing or confirming bank or trust company.

"Grantor" as used in connection with the establishment of a trust agreement means the entity that has established a trust for the ***sole*** benefit of the beneficiary. When established in conjunction with a reinsurance agreement, the grantor is the unlicensed, unaccredited assuming insurer.

"Insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or N.J.S.A. 17B-17-1 et seq.; any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.; any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.; any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.; or any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"NAIC" means the National Association of Insurance Commissioners.

"Net assets" means an insurer's total admitted assets less its total reserves and other liabilities.

"Obligations" as used in connection with the establishment of a trust agreement means:

1. Reinsured losses and allocated loss expenses paid by the ceding company, but not recovered from the assuming insurer;

2. Reserves for reinsured losses reported and outstanding;

3. Reserves for reinsured losses incurred but not reported; and

4. Reserves for allocated reinsured loss expenses and unearned premiums.

"Qualified United States financial institution":

1. As used at N.J.A.C. 11:2-28.8(b)3 and 28.10 means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof;

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies; and

iii. Has been determined by either the Commissioner, or the Securities Valuation Office of the NAIC, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the Commissioner; or

2. As used elsewhere in this subchapter means an institution that:

i. Is organized or, in the case of a branch or agency office of a foreign banking organization in the United States, licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

ii. Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

"Reinsurance" means a contractual arrangement, as evidenced by a written agreement, whereby an insurer, for some consideration, agrees to indemnify a ceding insurer, for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

"Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, which solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer unless expressly provided in a broker of record letter.

"Reinsurance intermediary-manager" means a person which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for that reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term, except that the following persons shall not be considered a reinsurance intermediary-manager, with respect to that reinsurer, for the purposes of this subchapter:

1. An employee of the reinsurer;

2. A United States manager of a United States branch of an alien reinsurer;

3. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to N.J.S.A. 17:27A-1 et seq., and whose compensation is not solely based on the volume of premiums written;

4. The manager of a group, association, pool or organization of insurers which engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or other similar regulatory officer of the state in which the manager's principal business office is located;

5. A licensed attorney-at-law who negotiates contracts or provides general financial counsel provided no commission or brokerage fee is provided.

"Substantially similar standards" means standards on credit for reinsurance which the Commissioner determines are equal to or exceed the standards of this subchapter.

"Surplus as regards policyholders" means the net assets of the insurer or assuming insurer.

11:2-28.3 Reinsurer licensed in New Jersey

An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where the assuming insurer is licensed to transact business in this State as of the date of the ceding insurer's statutory financial statement, except as limited in accordance with N.J.A.C. 11:2-27.

11:2-28.4 Reinsurer accredited in New Jersey

(a) An insurer shall be permitted to take a credit for reinsurance ***[which it cedes]*** ***ceded*** to an assuming insurer where the assuming insurer is accredited as a reinsurer in this State as of the date of the ceding insurer's statutory financial statement. An accredited reinsurer is one which meets all of the following standards:

1. Files with the Commissioner a letter requesting approval for accreditation and listing the information upon which it will rely and is submitting in connection therewith;

2. Submits a non-refundable filing fee made payable to Treasurer, State of New Jersey, of $1,000 for an initial filing and $1,000 for a renewal filing;

3. Files with the Commissioner a properly executed form AR-1 (incorporated herein by reference as Exhibit 1 in the Appendix) which establishes that it submits to this State's jurisdiction and this State's authority to examine its books and records;

4. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized, as evidence that it is currently

licensed to transact insurance or reinsurance in at least one state or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

5. Files annually with the Commissioner:

i. A copy of its most recent annual statement filed with the insurance department of its state of domicile;

ii. Its most recent audited financial statement;

iii. A current actuarial opinion which certifies:

(1) For a property and casualty insurer, to the adequacy of the loss and loss adjustment expense reserves; or

(2) For a life and health assuming insurer that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) That its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof; and

iv. The quarterly statement for the quarter immediately preceding the application, except for renewals which shall require the quarterly statement due May 15;

6. ***Either:***

i. Maintains a surplus as regards policyholders in an amount not less than $20,000,000 and whose accreditation has not been denied by the Commissioner within 120 days of filing its submission with the Commissioner*[,]***;*** or *[in the case of reinsurers with]*

ii. Maintains a surplus as regards policyholders of less than $20,000,000 whose accreditation has been approved by the Commissioner; and

7. Provides any additional information which may include, but is not limited to, information which the Commissioner deems necessary to ensure that the particular reinsurer's condition and methods of operation are not such as would render its operations hazardous to the public or its policyholders.

(b) The above information shall be filed with the Commissioner at:

Attention: Reinsurance Accreditation
Division of Financial Examinations
Department of Insurance
20 West State Street
[CN325] ***CN 325***
Trenton, New Jersey 08625

(c) *[An]* ***Except for applicants for accreditation that maintain surplus as regards policyholders of less than $20,000,000, an*** initial application for accreditation shall be deemed approved unless the Commissioner transmits a letter to the filer, within 120 days from the date of the filing of the completed application identifying the reasons upon which the Commissioner has denied the filer's accreditation. Where a filing is deemed approved, the initial approval shall be valid until August 31. If the initial approval is issued after June 1, it shall be deemed valid until August 31, of the following year.

(d) A reinsurer shall apply for renewal of its accreditation annually at the address in (b) above, to the attention of "Renewal Reinsurance Accreditation." The reinsurer shall file its application for renewal no later than June 1 of any year in which it seeks to continue its accreditation and shall submit updated information as required in (a) above.

(e) A renewal filed in accordance with the above shall be deemed approved unless denied by the Commissioner prior to August 31.

(f) An accredited reinsurer shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

1. Any limitation on its ability to write new or renewal business;

2. Any delinquency proceedings;

3. The suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;

4. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or

5. Any action by any state or jurisdiction requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

(g) Where the Commissioner determines that an assuming insurer has failed to maintain any of the qualifications set forth in (a)1 through 7 and (f) above, after written notice and opportunity for a hearing in accordance with the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq., the Commissioner may revoke or refuse to renew the assuming insurer's accreditation.

(h) The Department shall promulgate annually on October 31, a list of accredited reinsurers. The list shall be published in the New Jersey Register as a public notice.

(i) An insurer shall be prohibited from reporting a credit with respect to reinsurance ceded after 90 days from the date an assuming insurer has had its accreditation denied, revoked or nonrenewed.

11:2-28.5 Reinsurer domiciled and licensed in another state or jurisdiction which employs substantially similar standards to this subchapter

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer which, as of the date of the ceding insurer's statutory financial statement:

1. Is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer, is entered through and licensed in, a state which employs substantially similar standards regarding credit for reinsurance to those set forth in this subchapter;

2. Submits a non-refundable filing fee of $250.00 made payable to Treasurer, State of New Jersey;

3. Files with the Commissioner a certified copy of a certificate of authority, a certificate of compliance or an equivalent document which has been properly notarized as evidence that it is licensed to transact insurance or reinsurance in its state of domicile or, in the case of a United States branch of an assuming alien insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

4. Files with the Commissioner a properly executed form AR-1 (see Appendix) as evidence that it submits to this State's jurisdiction and authority to examine its books and records;

5. Files with the Commissioner a certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined by the factors set forth at N.J.A.C. 11:2-27.4. The officer shall certify that:

i. For a life and health assuming insurer, that:

(1) Its policy reserves are adequate; and

(2) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(3) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, and attaches any and all documents in support thereof;

ii. For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

iii. Except for reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system, that it maintains a surplus as regards policyholders in an amount not less than $20,000,000;

6. A reinsurer shall append to the certification set forth in (a)5 above, a certified balance sheet from the reinsurer's most recent annual statement;

7. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which the Commissioner has found that either the reinsurer's state or jurisdiction of domicile does not employ substantially similar standards or the reinsurer otherwise fails to satisfy the requirements of this subchapter;

8. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its ability to write new or renewal business;

ii. Any delinquency proceedings;

iii. A suspension, revocation or nonrenewal of its certificate of authority in any state or jurisdiction;

iv. An order or any action by any state or jurisdiction which requires it to cease writing new or renewal business; or

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

9. The above information shall be filed with the Commissioner at:

Attention: Reinsurance—Similar Standards
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2-28.6 Reinsurer maintaining trust funds

(a) An insurer shall be permitted to take a credit for reinsurance ceded to an assuming insurer where as of the date of the ceding insurer's statutory financial statement the assuming insurer meets the standards set forth in (a)1 and 2 below, in accordance with the procedures set forth in (a)3 through 8 below:

1. The assuming insurer maintains a trust fund in an amount prescribed in (b) below in a qualified United States financial institution for the payment of the valid claims of its United States policyholders and ceding insurers, their assigns and successors in interest.

2. The assuming insurer files with the Commissioner a letter requesting authorization to provide reinsurance. The letter shall specify: that the reinsurer seeks authorization based on the fact that it maintains trust funds for the benefit of its ceding insurers and United States policyholders; the location of the trust funds; and a list of documents and information submitted therewith and upon which the assuming insurer shall rely in connection with its request for authorization. The reinsurer shall submit to the Commissioner the following:

i. A nonrefundable filing fee made payable to Treasurer, State of New Jersey of $1,000 for an initial filing and $1,000 for a renewal filing;

ii. A properly executed form AR-1;

iii. A description of which categories of insurance are effected by the cessions;

iv. A certification executed by an authorized officer of the reinsurer which certifies that the reinsurer's condition and method of operations are financially sound and will not render its operations hazardous to the public or its policyholders as determined in accordance with the factors set forth at N.J.A.C. 11:2-27.4. The officer shall certify:

(1) For a life and health assuming insurer, that:

(A) Its policy reserves are adequate;

(B) It satisfies all minimum capital and surplus requirements in all states in which it is licensed to transact business; and

(C) Its capital and surplus levels are adequate relative to its distribution by type and level of risk of its invested assets and the business being written, together with any and all documents in support thereof;

(2) For a property and casualty assuming insurer, that net premium written to surplus as to policyholders does not exceed a 3:1 premium to surplus ratio and loss and loss adjustment expense reserve liability to surplus does not exceed a 4:1 ratio as of the date of the certified balance sheet from its most recent annual statement; and

(3) To the accuracy of the information required by (b) below;

v. A certified balance sheet from the reinsurer's most recent annual statement; and

vi. A list of the assets of the trust certified by the trustee.

3. The information in (a)1 and 2 shall be filed with the Commissioner at:

Attention: Reinsurance Trust Fund
Division of Financial Examinations
New Jersey Department of Insurance
20 West State Street
CN 325
Trenton, New Jersey 08625

4. A reinsurer shall reapply for authorization annually at the address set forth in (a)3 above no later than June 1 of each year.

5. Within 30 days from receipt of the information in (a)1 and 2 above the Commissioner shall notify the filer of any deficiencies in its submission and the filer shall have 30 days to cure such deficiencies.

6. Within 90 days from the date of receipt of the completed filing, the filing shall either be deemed approved or the Commissioner shall transmit a letter to the filer which identifies the reasons upon which he or she has relied to determine that the filer has not met the requirements of this section and that insurers shall be prohibited from reporting credits for reinsurance for insurance ceded to the filer.

7. A reinsurer authorized pursuant to this section shall notify the Commissioner within 30 days of the occurrence of any of the following actions taken against it by any state or jurisdiction:

i. Any limitation on its new or renewal business;

ii. Any delinquency proceedings;

iii. Its certificate of authority is suspended, revoked or nonrenewed in any state or jurisdiction;

iv. An order has been entered or any action has been taken by any state or jurisdiction which requires it to cease writing new or renewal business; *[and]* ***or***

v. Any action, by any state or jurisdiction, requiring that the reinsurer file a plan or any document to increase its capital, for example, a risk based capital plan.

8. An assuming insurer shall report annually to the Commissioner substantially the same information as that required to be reported on the NAIC annual statement form by licensed insurers to be evaluated by the Commissioner, including, but not limited to: a recent actuarial opinion which certifies to the adequacy of the loss and loss adjustment expense reserve liabilities, and, where applicable, life and health reserve liabilities, in order to determine the sufficiency of the trust fund; and any additional information the Commissioner deems necessary to ensure that the assuming insurer's condition and method of operation are not such as would render its operations hazardous to the public or policyholders in this State.

(b) In order to qualify as a reinsurer as provided in (a) above, an assuming insurer shall establish a trust fund. The trust fund established by the assuming insurer shall meet the following standards based upon the following category of assuming insurer into which it falls:

1. The trust fund for a single assuming insurer shall consist of a trusteed account *[representing]* ***in an amount not less than*** the assuming insurer's liabilities attributable to business written in the United States, and, in addition, a trusteed surplus of not less than $20,000,000.

2. The trust fund for a group of insurers, which group includes individual unincorporated underwriters, shall consist of a trusteed account *[representing]* ***in an amount not less than*** the group's aggregate liabilities attributable to business written in the United States and, in addition, the group shall maintain a trusteed surplus of *[which]* ***not less than*** $100,000,000 shall be held jointly for the benefit of the United States ceding insurers of any member of the group. The group shall make available to the Commissioner an annual certification of the solvency of each underwriter for the fiscal period immediately preceding, which fiscal period shall not be less than one year, by the group's domiciliary regulator and its independent certified public accountant.

3. The trust fund for a group of incorporated insurers under common administration which complies with the filing requirements set forth in this section whose members possess aggregate policyholder's surplus of $10,000,000,000, calculated and reported in

substantially the same manner as prescribed by the annual statement instructions and Accounting Practices and Procedures Manual of the NAIC, and which has continuously transacted an insurance business outside the United States for at least three years immediately prior to making application for accreditation, shall consist of funds in trust in an amount not less than the group's several liabilities *[pursuant]* ***attributable*** to business ceded by United States ceding insurers to any members of the group pursuant to reinsurance contracts issued in the name of such group and, in addition, the group shall maintain a joint trusteed surplus of which not less than $100,000,000 shall be held jointly and exclusively for the benefit of the United States ceding insurers of any member of the group. The group shall file a properly executed form AR-1 as evidence of its submission to this State's authority to examine the books and records of any of its members and shall certify that any member examined will bear the expense of any such examination. The group shall make available to the Commissioner annual certifications by the members' domiciliary regulators and their independent certified public accountants of the solvency of each member of the group for the fiscal period immediately preceding which fiscal period shall not be less than one year.

(c) The trust required by (b) above shall be established in a form approved by the Commissioner and in compliance with this section, and the content, location, legal currency and financial institutions shall be acceptable to the Commissioner. The trust instrument shall provide that:

1. Contested claims shall be valid and enforceable out of funds in trust to the extent remaining unsatisfied 30 days after entry of the final order of any court of competent jurisdiction in the United States;

2. Legal title to the assets of the trust shall be vested in the trustees of the trust for the benefit of the grantor's United States policyholders and ceding insurers, their assignees and successors in interest;

3. The trust shall be subject to examination as determined by the Commissioner;

4. The trust shall remain in effect for as long as the assuming insurer, or any member or former member of a group of insurers, shall have outstanding obligations due under reinsurance agreements subject to the trust;

5. No later than February 28 of each year the trustees of the trust shall report to the Commissioner in writing setting forth the balance of the trust and listing the trust's investments at the preceding year's end, and shall certify the date of termination of the trust, if so planned, or certify that the trust shall not expire prior to the next following December 31.

i. The trust assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender) investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or an affiliate of either the grantor or the beneficiary; and

6. No amendment to the trust shall be effective unless filed with and approved in advance by the Commissioner.

11:2-28.7 Credit for reinsurance required by law

(a) An insurer may be permitted to take a credit for reinsurance ceded to an assuming insurer which does not meet any of the requirements set forth at section 11:2-28.3, 28.4, 28.5 or 28.6, but only with respect to the insurance of risks located in jurisdictions where such reinsurance is required or provided by the applicable law or regulation of that jurisdiction. As used in this section, "jurisdiction" means any state, district or territory of the United States and any lawful national government.

(b) A credit may taken for insurance ceded by a *[domestic]* ***ceding*** insurer to a state owned or controlled insurance or reinsurance *[companies]* ***company*** or a ceding company participating in pools, guaranty funds or joint underwriting associations required by statute, regulation or administrative order.

11:2-28.8 Reduction from liability for reinsurance ceded to an unauthorized assuming insurer

(a) An insurer shall be permitted to take a reduction from liability for reinsurance ceded to an assuming insurer not meeting the requirements of N.J.A.C. 11:2-28.3, 28.4, 28.5, 28.6 or 28.7 in an amount which does not exceed the liabilities carried by the ceding insurer. Such reduction shall be in the amount of the funds held by or on behalf of the ceding insurer, including funds held in trust for the exclusive benefit of the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder. Such security shall be held in the United States subject to withdrawal solely by and under the exclusive control of the ceding insurer, or in the case of a trust held in a qualified United States financial institution, subject to withdrawal solely by and under the exclusive control of the ceding insurer.

(b) The security shall be in the form of:

1. Cash (United States legal tender);

2. Securities listed by the Securities Valuation Office of the NAIC and qualified as admitted assets;

3. Clean, irrevocable, evergreen, unconditional letters of credit issued or confirmed by a qualified United States institution no later than December 31st of the year for which filing is being made, and in the possession of the ceding company on or before the filing date of its annual statement. Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming qualified United States financial institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs, unless the issuer has been declared insolvent under applicable statutory or regulatory provisions; or

4. Any other form of security approved by the Commissioner upon formal request.

11:2-28.9 Trust agreements qualified pursuant to N.J.A.C. 11:2-28.8

(a) An admitted asset or a reduction from liability for reinsurance ceded to an unauthorized assuming insurer pursuant to N.J.A.C. 11:2-28.8 shall be permitted only when the requirements set forth below and in N.J.A.C. 11:2-28.10 and 28.11 are met.

1. The beneficiary, the grantor and a trustee shall enter into a trust agreement. The trustee shall be a qualified United States financial institution.

2. The trust agreement shall create a trust account into which the trust's assets shall be deposited.

3. All assets in the trust account shall be held by the trustee at the trustee's office in the United States, except that a bank may apply for the Commissioner's permission to use a foreign branch office of such bank as trustee for trust agreements established pursuant to this section. If the Commissioner approves the use of such foreign branch office as trustee, then its use must be approved by the beneficiary in writing and the trust agreement must provide that the written notice described in 4i below must also be presentable, as a matter of legal right, at the trustee's principal office in the United States. The trust assets shall consist of cash (United States legal tender), *[certificate]* ***certificates*** of deposit (issued by a United States bank and payable in United States legal tender), investments of stocks and bonds listed by the NAIC's Securities Valuation Office, or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the parent, subsidiary or an affiliate of either the grantor or the beneficiary.

4. The trust agreement shall provide that:

i. The beneficiary shall have the right to withdraw assets from the trust account at any time, without notice to the grantor, subject only to written notice from the beneficiary to the trustees;

ii. No other statement or document is required to be presented in order to withdraw assets, except that the beneficiary may be required to acknowledge receipt of withdrawn assets;

iii. It is not subject to any conditions or qualifications outside of the trust agreement; and

iv. It shall not contain references to any other agreements or documents except as provided below in (a)11 below.

5. The trust agreement shall be established for the *sole* benefit of the beneficiary.

6. The trust agreement shall require the trustee to:

i. Receive assets and hold all assets in a safe place;

ii. Determine that all assets are in such form that the beneficiary or the trustee, upon direction by the beneficiary, may whenever necessary negotiate any such assets, without consent or signature from the grantor or any other person or entity;

iii. Furnish to the grantor and the beneficiary a statement of all assets in the trust account upon its inception and at intervals no less frequent than the end of each calendar quarter;

iv. Notify the grantor and the beneficiary within ten days, of any deposits to or withdrawals from the trust account;

v. Upon written demand of the beneficiary, immediately take any and all steps necessary to transfer absolutely and unequivocally all right, title and interest in the assets held in the trust account to the beneficiary and deliver physical custody of the assets to the beneficiary; and

vi. Allow no substitutions or withdrawals of assets from the trust account, except on written instructions from the beneficiary, except that the trustee may, without the consent of, but with notice to, the beneficiary, upon call or maturity of any trust asset, withdraw such asset upon condition that the proceeds are paid into the trust account.

7. The trust agreement shall provide that at least 30 days, but not more than 45 days, prior to termination of the trust account, written notification of termination shall be delivered by the trustee to the beneficiary.

8. The trust agreement shall be made subject to and governed by the laws of the state in which the trust is established and shall at minimum conform to the standards set forth in these rules.

9. The trust agreement shall prohibit invasion of the trust corpus for the purpose of paying compensation to, or reimbursing the expenses of, the trustee.

10. The trust agreement shall provide that the trustee shall be liable for its own negligence, willful misconduct or lack of good faith.

11. Notwithstanding other provisions of this subchapter, when a trust agreement is established in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, where it is customary practice to provide a trust agreement for a specific purpose, such a trust agreement may provide that the ceding insurer shall undertake to use and apply amounts drawn upon the trust account, without diminution because of the insolvency of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, for the following purposes:

i. To pay or reimburse the ceding insurer for the assuming insurer's share under the specific reinsurance agreement regarding any losses and allocated loss expenses paid or owed by the ceding insurer, but not recovered from the assuming insurer, or for unearned premiums due to the ceding insurer if not otherwise paid by the assuming insurer;

ii. To make payment to the assuming insurer of any amounts held in the trust account that exceed 102 percent of the actual amount required to fund the assuming insurer's obligations under the specific reinsurance agreement; or

iii. Where the ceding insurer has received notification of termination of the trust account and where the assuming insurer's entire obligations under the specific reinsurance agreement remain unliquidated and undischarged 10 days prior to the termination date, to withdraw amounts equal to the obligations and deposit those amounts in a separate account, in the name of the ceding insurer in any qualified United States financial institution apart from its general assets, in trust for such uses and purposes specified in (a)11i and (a)11ii above as may remain executory after such withdrawal and for any period after the termination date.

12. The trust agreement shall provide that the trustee shall resign upon delivery of a written notice of resignation, effective not less than 90 days after receipt by the beneficiary and grantor of the notice and that the trustee may be removed by the grantor by delivery to the trustee and the beneficiary of a written notice of removal, effective not less than 90 days after receipt by the trustee and the beneficiary of the notice, provided that no such resignation or removal shall be effective until a successor trustee has been duly appointed and approved by the beneficiary and the grantor and all assets in the trust have been duly transferred to the new trustee.

(b) The trust agreement may provide for the following conditions:

1. That the grantor may have the full and unqualified right to vote any shares of stock in the trust account and to receive from time to time payments of any dividends or interest upon any shares of stock or obligations included in the trust account. Any such interest or dividends may be either forwarded promptly upon receipt to the grantor or deposited in a separate account established in the grantor's name;

2. That the trustee may have the authority to invest and accept substitutions of any funds in the account, provided that no investment or substitution may be made without prior approval of the beneficiary, unless the trust agreement specifies categories of investments acceptable to the beneficiary and authorizes the trustee to invest funds and to accept substitutions which the trustee determines are at least equal in market value to the assets withdrawn and that are consistent with the restrictions in (c)1ii below;

3. The beneficiary may at any time designate a party to which all or part of the trust assets are to be transferred. Such transfer may be conditioned upon the trustee receiving, prior to or simultaneously, other specified assets; and

4. Upon termination of the trust account, all assets not previously withdrawn by the beneficiary shall, with written approval by the beneficiary, be delivered over to the grantor.

(c) A reinsurance agreement may provide provisions to be included in a trust agreement and the trust account established thereunder.

1. A reinsurance agreement, which is entered into in conjunction with a trust agreement and the establishment of a trust account, may contain provisions that:

i. The assuming insurer may enter into a trust agreement and may establish a trust account for the benefit of the ceding insurer and specify what the agreement is to cover;

ii. Assets deposited in the trust account shall be valued according to their current fair market value and shall consist only of cash (United States legal tender), certificates of deposit (issued by a United States bank and payable in United States legal tender), and investments of stocks and bonds listed by the NAIC's Securities Valuation Office or any obligations issued by the State of New Jersey or any of its political subdivisions, or any combination of the above, provided that such investments are issued by an institution that is not the grantor, beneficiary, parent, subsidiary or affiliate of either the grantor or the beneficiary. The reinsurance agreement shall specify the types of investments to be deposited. Where a trust agreement is entered into in conjunction with a reinsurance agreement covering risks other than life, annuities and accident and health, then the trust agreement may contain the provisions required by this paragraph in lieu of including such provisions in the reinsurance agreement;

iii. The reinsurance agreement entered into in conjunction with the trust agreement may, but need not include the provisions required by (c)1ii above, so long as the conditions required in (a) above are included in the trust agreement.

iv. The assuming insurer, prior to depositing assets with the trustee, shall execute assignments or endorsements in blank, or transfer legal title to the trustee of all shares, obligations or any other assets requiring assignments, in order that the ceding insurer, or the trustee upon the direction of the ceding insurer, may, whenever necessary, negotiate these assets without consent or signature from the assuming insurer or any other entity;

v. All settlements of account between the ceding insurer and the assuming insurer shall be made in cash or its equivalent; and

vi. The assuming insurer and the ceding insurer shall agree that the assets in the trust account, established pursuant to the provisions of the reinsurance agreement, may be withdrawn by the ceding insurer at any time, notwithstanding any other provisions in the reinsurance agreement, and shall be utilized and applied by the ceding insurer or its successors in interest by operation of law, including without limitation any liquidator, rehabilitator, receiver or conservator of such company, without diminution because of insolvency on the part of the ceding insurer or the assuming insurer or the inability of the ceding insurer to pay all or any part of a claim, only for the following purposes:

(1) To reimburse the ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement because of cancellations of such policies;

(2) To reimburse the ceding insurer or pay an insolvent ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer or owed by an insolvent ceding insurer pursuant to the provisions of the policies reinsured under the reinsurance agreement;

(3) To fund an account with the ceding insurer in an amount at least equal to the deduction, for reinsurance ceded, from the *[ceded]* ***ceding*** insurer liabilities for policies ceded under the agreement. The account shall include, but not be limited to, amounts for policy reserves, claims and losses incurred, including losses incurred but not reported, loss adjustment expenses and unearned premium reserves; and

(4) To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

2. The reinsurance agreement may also contain provisions that:

i. The assuming insurer may seek approval from the ceding insurer to withdraw from the trust account all or any part of the trust assets and transfer those assets to the assuming insurer, and the ceding insurer shall not unreasonably or arbitrarily withhold its approval provided:

(1) The assuming insurer shall, at the time of withdrawal, replace the withdrawn assets with other qualified assets having a market value equal to the market value of the assets withdrawn so as to maintain at all times the deposit in the required amount; or

(2) After withdrawal and transfer, the market value of the trust account is no less than 102 percent of the required amount;

ii. Any amount withdrawn in excess of the actual amounts required for (c)1vi(1), (2) and (3) or in the case of (c)1vi(4) any amounts that are subsequently determined not to be due shall be returned;

iii. Interest shall be paid at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to subsection (c)1vi(3); and

iv. An award by any arbitration panel or court of competent jurisdiction shall be permitted for:

(1) Interest at a rate different from that provided in iii above;

(2) Court of arbitration costs;

(3) Attorney's fees; and

(4) Any other reasonable expenses.

3. The reinsurance agreement shall contain a provision, if applicable, which requires that a reinsurance intermediary*[:

i. Is a fiduciary for the reinsurer; and

ii. Shall]* ***shall*** hold any and all funds collected on the reinsurer's behalf, in a fiduciary capacity, in a qualified United States financial institution.

(d) A trust agreement may be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer as reflected in financial statements required to be filed with the Department in compliance with the provisions of this subchapter when established on or before the date of filing of the financial statement of the ceding insurer. The reduction for the existence of an acceptable trust account may be up to the current fair market value of acceptable assets available to be withdrawn from the trust account at that time, but such reduction shall be no greater than the specific obligations under the reinsurance agreement that the trust account was established to secure.

(e) Any trust agreement or underlying reinsurance agreement in existence prior to August 16, 1993 shall be acceptable until February 12, 1994, at which time any and all trust agreements shall comply with this subchapter.

(f) The failure of any trust agreement to specifically identify the beneficiary shall not be construed to affect any actions or rights which the Commissioner may take or possess pursuant to the provisions of the laws of this State.

11:2-28.10 Letters of credit qualified pursuant to N.J.A.C. 11:2-28.8

(a) A letter of credit shall be clean, irrevocable, evergreen, and unconditional and issued or confirmed by a qualified United States financial institution. The letter of credit shall contain an issue date and date of expiration and shall stipulate that the beneficiary need only draw a sight draft under the letter of credit and present it to obtain funds and that no other document need be presented. The letter of credit shall also indicate that it is not subject to any condition or qualifications outside of the letter of credit. The letter of credit itself shall not contain reference to any other agreements, documents or entities, except as provided in (i)1 below. If a court of law appoints a successor in interest to the named beneficiary, then the named beneficiary includes and is limited to the court appointed domiciliary receiver, conservator, rehabilitator or liquidator.

(b) The heading of the letter of credit may include a boxed section which contains the name of the applicant and other appropriate notations to provide a reference for the letter of credit. The boxed section shall be clearly marked to indicate that such information is for internal identification purposes only.

(c) The letter of credit shall contain a statement to the effect that the obligation of the qualified United States financial institution under the letter of credit is in no way contingent upon reimbursement with respect thereto.

(d) The term of the letter of credit shall be for at least one year and shall contain an "evergreen clause" which prevents the expiration of the letter of credit without due notice to the named beneficiary from the issuing financial institution. The "evergreen clause" shall provide for a period of no less than 30 days' notice prior to expiry date or nonrenewal.

(e) The letter of credit shall state whether it is subject to and governed by the laws of this State or the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400 or any subsequent revisions, and all drafts drawn thereunder shall be presentable at an office in the United States of a qualified United States financial institution.

1. Publication 400 can be obtained by contacting ICC Publishing, Inc. at (212) 206-1150 or by writing to it at 156 Fifth Avenue, STE 820, New York, New York 10010 and remitting the appropriate fees.

(f) If the letter of credit is made subject to the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce, Publication 400, then the letter of credit shall specifically address and make provision for an extension of time to draw against the letter of credit in the event that one or more of the occurrences specified in Article 19 of Publication 400 occur.

(g) The letter of credit shall be issued or confirmed by a qualified United States financial institution authorized to issue letters of credit in accordance with these rules.

(h) Where a letter of credit is issued by a United States financial institution authorized to issue letters of credit, other than a qualified United States financial institution as described in (g), the following additional requirements shall be met:

1. The issuing United States financial institution shall formally designate the confirming qualified United States financial institution as its agent for the receipt and payment of the drafts; and

2. The "evergreen clause" shall provide for 30 days' notice to the named beneficiary or its successors in interest from the issuing financial institution prior to expiry date *[or]* ***for*** nonrenewal.

(i) A reinsurance agreement, in conjunction with which a letter of credit is obtained, may contain the following provisions:

1. The assuming insurer shall provide letters of credit to the ceding insurer and specify what they are to cover.

2. The assuming insurer and ceding insurer shall agree that the letter of credit provided by the assuming insurer pursuant to the provisions of the reinsurance agreement may be drawn upon at any time, notwithstanding any other provisions in the agreement, and shall be utilized by the ceding insurer or its successors in interest only for one or more of the following reasons:

i. To reimburse the ceding insurer or to pay an insolvent ceding insurer for the assuming insurer's share of premiums returned to the owners of policies reinsured under the reinsurance agreement on account of cancellations of such policies;

ii. To reimburse the ceding insurer for the assuming insurer's share of surrenders and benefits or losses paid by the ceding insurer or owed by an insolvent ceding insurer under the terms and provisions of the policies reinsured under the reinsurance agreement;

iii. To fund an account with the ceding insurer in an amount at least equal to the deduction for reinsurance ceded from the ceding insurer's liabilities for policies ceded under the agreement. Such amount shall include, but not be limited to, amounts for policy reserves, claims and losses incurred and unearned premium reserves; or

iv. To pay any other amounts the ceding insurer claims are due under the reinsurance agreement.

3. The provisions of (i)1 and 2 above shall be applied without diminution because of insolvency on the part of the ceding insurer or assuming insurer.

4. Nothing contained in (i)1 and 2 above shall preclude the ceding insurer and assuming insurer from providing for:

i. An interest payment, at a rate not in excess of the prime rate of interest as reported in the Federal Reserve Bulletin, on the amounts held pursuant to (i)2iii above; or

ii. The return of any amounts drawn down on the letters of credit in excess of the actual amounts required for the above or, in the case of (i)2iv above, any amounts that are subsequently determined not to be due.

5. When a letter of credit is obtained in conjunction with a reinsurance agreement covering risks other than life, annuities and health, where it is customary practice to provide a letter of credit for a specific purpose, then the reinsurance agreement may, in lieu of (i)2 above, require that the parties enter into a "Trust Agreement" which may be incorporated into the reinsurance agreement or be a separate document.

(j) A letter of credit may not be used to reduce any liability for reinsurance ceded to an unauthorized assuming insurer as reflected in financial statements required to be filed with the Department unless an acceptable letter of credit with the filing ceding insurer as beneficiary has been issued on or before the date of filing of the financial statement. The reduction for the letter of credit may be up to the amount available under the letter of credit but no greater than the specific obligation under the reinsurance agreement which the letter of credit was intended to secure.

11:2-28.11 Other security

A ceding insurer may take credit for unencumbered funds withheld by the ceding insurer in the United States in connection with the reinsurance contract under which those funds are withheld, subject to withdrawal solely by the ceding insurer and under its exclusive control.

11:2-28.12 Reinsurance contract

(a) Credit will not be granted to a ceding insurer for reinsurance effected with assuming insurers meeting the requirements of N.J.A.C. 11:2-28.3, 28.4, 28.5, 28.6, or 28.8 ***of this subchapter*** unless the reinsurance agreement ***meets the following standards***:

*[1. Includes a proper insolvency clause which provides that in the event of the insolvency of the ceding insurer, reinsurance proceeds will be paid to the ceding insurer or its liquidator, rehabilitator, receiver or other statutory successor on the basis of the amount of the claim allowed in the insolvency proceeding, without diminution by reason of the inability of the ceding insurer to pay all or any part of the claim, except that credit is allowed:

i. Where the contract specifically provides for another payee of such reinsurance, acceptable to the Commissioner, in the event of the insolvency of the ceding insurer; and

ii. Where the assuming insurer, with the consent of the direct insured or insureds, has assumed such policy obligations of the ceding insurer as direct obligations of the assuming insurer to the insureds under such policies and in substitution for the obligations of the ceding insurer to such insureds; and

2. Includes a provision whereby the assuming insurer, if an unauthorized assuming insurer, has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States, has agreed to comply with all requirements necessary to give such court or panel jurisdiction, has designated an agent upon whom service of process may be effected, and has agreed to abide by the final decision of such court or panel.

(b) The insolvency clause shall include the following provisions:

1. The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement;

2. In the event of insolvency and the appointment of a rehabilitator, conservator, liquidator or statutory successor of the ceding company, the reinsurance obligation shall be payable to such rehabilitator, conservator, liquidator or statutory successor immediately upon demand, with reasonable provision for verification, on the basis of claims allowed against the insolvent company by any court of competent jurisdiction or by any conservator, liquidator, or statutory successor of the company having authority to allow such claims, without diminution because of such insolvency or because such rehabilitator, conservator, liquidator or statutory successor has failed to pay all or a portion of any claims. Payments by the reinsurer as set forth above shall be made directly to the ceding insurer or to its rehabilitator, conservator, liquidator or statutory successor;

3. The rehabilitator, conservator, liquidator or statutory successor of a ceding insurer shall give written notice of the pendency of a claim against the ceding insurer indicating the policy or bond reinsured, within a reasonable time after such claim is filed. The receiver, rehabilitator, conservator or liquidator of an insolvent ceding company shall seek to arrange for the giving of notice of the pendency of claims on reinsured policies by the liquidator or by guaranty funds or by other persons responsible for the adjustment and settlement of the insolvent ceding company claims. Failure to give such notice shall not excuse the obligation of the reinsurer unless it is substantially prejudiced thereby. If no part of the claim is covered by a guaranty association act or similar act, the reinsurer may interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding company or its conservator, liquidator or statutory successor. The expense thus incurred by the reinsurer shall be payable subject to court approval, out of the estate of the insolvent ceding insurer as part of the expense of conservation, rehabilitation, or liquidation to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in conservation, rehabilitation, or liquidation, solely as a result of the defense undertaken by the reinsurer; and

4. Payments by the reinsurer shall be made directly to the ceding insurer to its conservator, liquidator or statutory successor, except where the contract of insurance or reinsurance specifically provides another payee for such reinsurance in the event of insolvency of the ceding insurer.]*

***1. Includes a provision that if the assuming insurer is an unauthorized assuming insurer;**

i. It has submitted to the jurisdiction of an alternative dispute resolution panel or court of competent jurisdiction within the United States;

ii. It has agreed to comply with all requirements necessary to give such court or panel jurisdiction;

iii. It has designated an agent upon whom service of process may be effected; and

iv. It has agreed to abide by the final decision of such court or panel; and

2. Includes an insolvency clause which shall provide the following:

i. In the event of a receivership, the reinsurance recoverables due under any reinsurance contract shall be payable by the reinsurer directly to the receiver, after reasonable provision for verification, on the basis of claims allowed against the insolvent company by any court or competent jurisdiction having authority to allow such claims or allowed by the receiver as a result of the conclusion of the claim filing, approval and appeal process before the receiver. Regardless of any provision in the reinsurance contract or other agreement to the contrary, payment shall be made without diminution because of such insolvency or because the receiver has failed to pay all or a portion of any claims;

ii. The receiver of a ceding insurer shall give or arrange to give to the reinsurer, written notice of the pendency of a claim against the ceding insurer, within a reasonable period of time after the initiation of the receivership. Failure to give such notice shall not excuse the obligation of the reinsurer unless it is substantially prejudiced thereby. The reinsurer may interpose, at its own expense, in the proceeding where such claim is to be adjudicated, any defense or defenses which it may deem available to the ceding company or its receiver. The reasonable expense thus incurred by the reinsurer shall be payable, subject to court approval, out of the estate of the insolvent ceding insurer as part of the expense of the receivership to the extent of a proportionate share of the benefit which may accrue to the ceding insurer in receivership, solely as a result of the defense undertaken by the reinsurer; and

iii. Payments by the reinsurer shall be made directly to the receiver of the ceding insurer except where the contract of insurance or reinsurance specifically provides another payee for such reinsurance in the event of the insolvency of the ceding insurer.*

11:2-28.13 Contracts affected

All new and renewal reinsurance transactions entered into after February 5, 1994 shall meet the standards set forth in this chapter if credit is to be given to the ceding insurer for such reinsurance.

APPENDIX

FORM AR-1
CERTIFICATE OF ASSUMING INSURER

I,_____ (name of officer), _____ (title of officer) of _____ (name of assuming insurer), the assuming insurer under a reinsurance agreement(s) with one or more insurers domiciled in_____ (name of state), hereby certify that _____ (name of assuming insurer) ("Assuming Insurer"):

1. Submits to the jurisdiction of any court of competent jurisdiction in _____ (ceding insurer's state of domicile) for the adjudication of any issues arising out of the reinsurance agreement(s), agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement(s) to arbitrate their disputes if such an obligation is created in the agreement(s).

2. Designates the Insurance Commissioner of_____ _____ (ceding insurer's state of domicile) as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement(s) instituted by or on behalf of the ceding insurer.

3. Submits to the authority of the Insurance Commissioner of _____ (ceding insurer's state of domicile) to examine its books and records and agrees to bear the expense of any such examination.

4. Submits with this form a current list of insurers domiciled in _____ (ceding insurer's state of domicile) reinsured by Assuming Insurer and undertakes to submit additions to or deletions from the list to the Insurance Commissioner at least once per calendar quarter.

Dated:_____ _____ (name of assuming insurer)

BY: _____ (name of officer)

_____ (title of officer)

[REG11228/LRWPC] ***REG11228.A/LRWPC***

(a)

DIVISION OF FINANCIAL EXAMINATIONS AND LIQUIDATIONS

Surplus Lines Insurance: Allocation of Premium Tax and Surcharge

Adopted New Rules: N.J.A.C. 11:2-34

Proposed: May 3, 1993 at 25 N.J.R. 1826(a).
Adopted: October 21, 1993 by Samuel F. Fortunato, Commissioner Department of Insurance.
Filed: October 21, 1993 as R.1993 d.582, **without change**.

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), 17:22-6.57, 6.58, 6.59, 6.61, 6.64, 6.65, 6.73, 6.75(2), 6.76, and 54:49-3 and 4.

Effective Date: November 15, 1993.
Expiration Date: November 30, 1995.

Summary of Public Comments and Agency Responses:

One public comment was received from the Surplus Lines Association of New Jersey, Inc.

COMMENT: The commenter questioned how the New Jersey surplus lines agent should address situations in which a portion of the risk or exposure is not in New Jersey. The commenter stated that, for example, if they have a risk domiciled in New Jersey but with one half of its exposure in Florida, once they pay New Jersey taxes what do they do with the remainder.

Additionally, the commenter questioned how should the New Jersey surplus lines agent file taxes for out-of-State exposures or risks, and how should agents calculate what tax the insured should be charged.

RESPONSE: These rules provide a method by which the surplus lines premium receipt tax and assessments are computed on the portion of the premium allocable to risk or exposures **in this State.** The Department does not have the authority to determine the method by which taxes and assessments are computed or paid on exposures or risks for other states. In order to determine this procedure, the surplus lines agent should contact the specific state for which he or she is required to pay taxes.

COMMENT: The commenter questioned whether surplus lines agents need to complete a surplus lines affidavit for each state in which the insured has risks or exposures.

RESPONSE: These rules require a New Jersey surplus lines affidavit to be completed for each placement with risks or exposures **in this State.**

COMMENT: The commenter questioned whether surplus lines agents need to file an affidavit in cases where the insured is domiciled in New Jersey but has the majority of its exposures in another state.

RESPONSE: The New Jersey surplus lines agent is required to file an affidavit and collect taxes from the insured on the **portion** of premium allocable to risks or exposures **in this State,** pursuant to N.J.S.A. 17:22-6.40 et seq. and these rules.

Full text of the adoptions follows:

SUBCHAPTER 34. SURPLUS LINES INSURANCE: ALLOCATION OF PREMIUM TAX AND SURCHARGE

11:2-34.1 Purpose and scope

(a) This subchapter sets forth the method by which the surplus lines premium receipts tax imposed pursuant to N.J.S.A. 17:22-6.59 and 6.64 and the New Jersey Surplus Lines Insurance Guaranty Fund assessment imposed pursuant to N.J.S.A. 17:22-6.75 is computed on the portion of the premium which is properly allocable to the risks or exposures located within this State.

(b) This subchapter applies to all surplus lines agents and insureds required to forward premium receipts tax to the Commissioner pursuant to N.J.S.A. 17:22-6.59 and 6.64, and assessments to the New Jersey Surplus Lines Insurance Guaranty Fund pursuant to N.J.S.A. 17:22-6.75a(2).

11:2-34.2 Definitions

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

"Allocation Schedule" means the schedule in the Appendix to this subchapter incorporated by reference which sets forth the criteria for tax allocation to New Jersey of a portion of the premium of multi-state risks.

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

"Department" means the New Jersey Department of Insurance.

"Guaranty fund" means the New Jersey Surplus Lines Insurance Guaranty Fund created by N.J.S.A. 17:22-6.73.

"Located in New Jersey" or "in New Jersey" means a physical presence in or headquartered in the State of New Jersey.

"Surplus lines agent" means an individual licensed pursuant to N.J.S.A. 17:22A-1 et seq. and N.J.A.C. 11:17-2.2 to place insurance coverages with unauthorized insurers.

"Surplus lines insurer" means an unauthorized insurer which is eligible for placement of insurance coverage pursuant to N.J.S.A. 17:22-6.42, 6.43 and 6.45.

"Unauthorized insurer" means an insurer that is not duly authorized to transact business in this State by a current certificate of authority issued pursuant to N.J.S.A. 17:17-1 et seq. for domestic insurance companies and N.J.S.A. 17:32-1 et seq. for foreign companies, and any other laws of this State.

11:2-34.3 Allocation of premium tax and surcharge

(a) Each surplus lines agent shall on or before the end of the month next following each year calendar quarter file with the Commissioner a verified report in duplicate of all surplus lines insurance transacted, or not transacted, during such calendar quarter as set forth in N.J.S.A. 17:22-6.58. The surplus lines agent shall collect from the insured and forward to the Commissioner the appropriate amount of tax collected for each quarterly period as set forth in N.J.S.A. 17:22-6.59 which shall be allocated as set forth in this subchapter when a surplus lines policy covers risks or exposures only partially located within this State.

(b) Premiums charged by eligible surplus lines insurers in this State are subject to a surcharge of up to four percent calculated in accordance with N.J.S.A. 17:22-6.75(2). The surplus lines agent shall collect from the insured and forward to the Fund the amount of the surcharge on a quarterly payment basis.

(c) The surplus lines agent or insured shall determine the premium and surcharge properly allocable to risks or exposures located in this State by using the method of allocation according to the Allocation Schedule set forth in the Appendix to this subchapter, which is hereby incorporated by reference, which pertains to the classification describing the coverage.

(d) If the Allocation Schedule does not identify a classification appropriate to the property or risk located in this State, the surplus lines agent or insured shall use an alternative equitable method of allocation for the property or risk.

(e) If a policy covers more than one classification:

1. For any portion of the coverage identified by a classification on the Allocation Schedule, the tax shall be computed using the Allocation Schedule for the corresponding portion of the premiums.

2. For any portion of the coverage not identified by a classification on the Allocation Schedule, the tax shall be computed as set forth in (d) above.

3. For any portion of the coverage where the premium is indivisible, the tax shall be computed by using the method of allocation that pertains to the classification on the Allocation Schedule describing the predominant coverage.

(f) If, in the opinion of the Commissioner, the information provided by the surplus lines agent or insured is insufficient to support its method of allocation, or if the Commissioner determines that the method used is incorrect, the Commissioner shall determine an equitable and appropriate method of allocation as follows:

1. If the Allocation Schedule identifies a classification appropriate to the coverage, the Commissioner shall use the method of allocation as set forth in (c) above.

2. If the Allocation Schedule does not identify the classification appropriate to the coverage, the Commissioner, in determining an alternate method of allocation, shall give significant weight to documented evidence of the underwriting exposure basis and any other criteria used by the insurer to determine the policy premium. The Commissioner may also consider other available information to the extent he or she finds the information sufficient and relevant, including, but not limited to, the following:

i. The percentage of the insured's physical assets in this State;

ii. The percentage of the insured's employee payroll in this State;

iii. The percentage of the insured's sales in this State; and

iv. The amount of premium tax paid to another jurisdiction.

(g) The listing of any coverage of insurance in the Allocation Schedule shall not mean that such coverage has been deemed by the Commissioner as eligible for export. No coverage shall be eligible for export unless the conditions set forth in N.J.S.A. 17:22-6.43 are satisfied.

11:2-34.4 Duty to file allocation form

(a) The surplus lines agent shall file a copy of the work sheets which show the method of allocation when it employs an alternative method of allocation to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22-6.57 and 6.58 and all renewals, until such time as a different method is approved and filed.

(b) The insured or self-insured shall file a copy of the allocation form when it employs an alternative method of allocation to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22-6.64 and 6.65, and all renewals, until such time the alternative method is approved and filed.

11:2-34.5 Duty to keep records

(a) The surplus lines agent shall maintain records concerning the method used to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22-6.57 and 6.58, including those records as indicated in the allocation schedule, and all renewals, for a period not less than three years.

(b) The insured or self insured shall maintain records concerning the method used to compute the surplus lines insurance premium tax in accordance with N.J.S.A. 17:22-6.64 and 6.65, including those records as indicated in the allocation schedule, and all renewals, for a period not less than three years.

(c) These records shall be available for review by the Department at all times and copies shall be provided to the Surplus Lines Examining Office of the Department, upon request, at any time during the period of retention.

11:2-34.6 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law including, but not limited to, N.J.S.A. 17:22-6.61, 6.64 and 6.76.

APPENDIX

SURPLUS LINES PREMIUM TAX AND
ALLOCATION SCHEDULE

Criteria for Tax
Allocation of Multi-State Risks

CLASSIFICATION	ALLOCATED TO NEW JERSEY BY
PROPERTY INSURANCE	
Real Property (including buildings and other permanent additions)	Insured value of structures and other property in New Jersey
Personal Property (including inland marine)	Insured value of property permanently or principally situated in New Jersey
Business Interruption, Time Element or similar time valued coverages	Insured time valued elements in New Jersey
Farmowners, Homeowners and Businessowners (BOP)	Insured value of structures and other property in New Jersey
Aircraft	Insured value of aircraft principally hangared in New Jersey
Motor Vehicle	Insured value of motor vehicles principally garaged in New Jersey
Kidnap and Ransom	Number of insured employees principally employed in New Jersey
Ocean Marine	None to New Jersey
FIDELITY AND SURETY	
Fidelity, Forgery and other Indemnity Bonds	Number of insured employees in New Jersey
Bankers Blanket Bonds	Number of insured employees in New Jersey
Performance Bonds	Total bond value of contracts in New Jersey
Other Surety Bonds	Total bond value of contracts in New Jersey
CREDIT INSURANCE	
Credit Insurance	Value of insured debt in New Jersey
RESIDUAL VALUE INSURANCE	
Residual Value Insurance	Allocate to value of underlying property
LIABILITY INSURANCE	
Manufacturers and Contractors	Payroll in New Jersey
Premises Operations	Square footage of premises in New Jersey
Owners and Contractors Protective	Cost of contract in New Jersey
Products	Number of units manufactured in New Jersey
Completed Operations	Receipts in New Jersey
Child Care	Number of children in New Jersey
Contractual	If "stand alone" policy, value of sales in New Jersey
Recreational	Amount of gate receipts in New Jersey
Environmental Impairment	Number of units of exposure in New Jersey
Asbestos Abatement	Payroll in New Jersey
Employee/Member Benefit Program	Number of employees/members in New Jersey
Special Events	Number of events in New Jersey
Professional Liability	Number of named insureds in New Jersey
Errors and Omissions	Revenues generated in New Jersey
Directors and Officers:	
For-profit organization	Revenues generated in New Jersey Number of employees
Not-for-profit organization	Headquartered in New Jersey
Hospital, Nursing Home and Adult Home	Number of beds in New Jersey plus one additional bed for each 100 outpatient visits at locations in New Jersey
Liquor Liability	Receipts from sales of alcoholic beverages in New Jersey
Railroad Protective	Miles of track in New Jersey
Aircraft	Number of aircraft principally hangared in New Jersey
Motor Vehicle	Number of motor vehicles principally garaged in New Jersey
Umbrella	Classification of predominant coverage; except if underlying coverages are divisible, then use underlying classifications
Excess Liability	If directly over primary, use underlying classifications. If over umbrella, use method for "umbrella" coverage
Comprehensive General Liability	Composite Rated Exposure based allocated to New Jersey

(a)

DIVISION OF FINANCIAL EXAMINATIONS
Risk Retention Groups and Purchasing Groups
Adopted Concurrent New Rules: N.J.A.C. 11:2-36

Proposed: September 7, 1993 at 25 N.J.R. 4298(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.558, **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. 17:1-8.1, 17:1C-6(e), and P.L. 1993, c.240 (enacted August 9, 1993).
Effective Date: October 15, 1993, Readoption of emergency rules;
November 15, 1993, Changes upon adoption.
Expiration Date: November 30, 1995.

These new rules were adopted on an emergency basis and concurrently reproposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-1(c) (see 25 N.J.R. 4298(a)). The present adoption of these concurrent reproposed rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for the changes upon adoption, which are effective upon publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

One public comment was received from a risk retention group (Preferred Physicians Mutual).

COMMENT: One commenter expressed its concern with providing a complete list of its membership. The commenter believes that requiring a nationwide membership list goes beyond even New Jersey's regulatory intent and authority and could be construed as an additional obligation not specifically authorized by the Risk Retention Act. The commenter stated that the Department is asking for a renewal listing of all of its insureds. The commenter stated that no other standard type company or agency is ever asked by the Department to provide critical information as this. This commenter believes that there are other methods available (that is, affidavits) which can be used to verify the Department's requirements which do not require the release of "protected" information. The commenter also expressed concern that it has no assurances that this highly proprietary information will be protected and not fall into the hands of its competitors. The commenter also stated that even if the list is designated as proprietary by the Department, oversights can inadvertently happen which may allow a competitor access to this data. The commenter further stated that its policyholders would object to their names and addresses being provided to any outside source without their specific written consent.

RESPONSE: The Department recognizes that for its regulatory purposes, the requisite membership information may be verified by a certification in lieu of requiring a listing of all members participating in a risk retention group. Therefore, the Department has deleted from N.J.A.C. 11:2-36.3 and Appendix A the requirement that a risk retention group provide a listing of all its participating members. Also, the reference in Appendix D to "Risk Retention Group" has been corrected to "Purchasing Group."

Full text of the adoption follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated with brackets and asterisks *[thus]*):

SUBCHAPTER 36. RISK RETENTION GROUPS AND PURCHASING GROUPS

11:2-36.1 Purpose and scope

(a) The purpose of this subchapter is to regulate in this State the formation and/or operation of:

1. Foreign or alien risk retention groups; and

2. Purchasing groups formed in the United States pursuant to 15 U.S.C. §3901 et seq.

(b) This subchapter applies to:

1. All foreign or alien risk retention groups and their legal representatives, who are doing or intend to do business in this State; and

2. All purchasing groups with members located in this State and their legal representatives, who are doing or intend to do business in this State.

11:2-36.2 Definitions

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

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

"Doing business in this State" means solicitation in this State, having group members in this State, or having an office in this State.

"Domicile" means, with respect to a purchasing group: for a corporation, the state in which the purchasing group is incorporated; for an unincorporated entity, the state of its principal place of business.

"Insurance" means primary insurance, excess insurance, reinsurance, surplus line insurance and any other arrangement for shifting and distributing risk which is determined to be insurance pursuant to the laws of the State.

"Liability" means legal liability for damages, including the cost of defense, legal costs and fees, and other claims expenses, because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of: any profit or non-profit business, trade, product, services, including professional services, premises, or operations; or any activity of any state or local government or any agency or political subdivision thereof, but does not include personal risk liability or an employer's liability with respect to its employees other than legal liability under the Federal "Employers' Liability Act," 45 U.S.C. §51 et seq.

"Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of the risk retention group, including: information sufficient to verify that its members are engaged in business or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; for each state in which it intends to operate, the coverages, deductibles, coverage limits, rates, and rating classification systems for each line of insurance the group intends to offer; historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available; pro forma financial statements and projections; appropriate opinions by a qualified actuary, including the determination of minimum premium or participation levels and capitalization required to commence operations and to prevent a hazardous financial condition, which shall be in the format and otherwise satisfy all requirements established by the Commissioner for loss reserve actuarial opinions required to be submitted by licensed property and casualty insurers in this State; identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements; identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and such other matters as may be prescribed by the commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

"Purchasing group" means any group which has as one of its purposes the purchase of liability insurance on a group basis; purchases such insurance only for its group members and only to cover their similar or related liability exposure; is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and is domiciled in this or any other state.

"Risk retention group" means any corporation or other limited liability association: which is organized for the primary purpose of, and whose primary activity consists of, assuming and spreading all, or any portion, of the liability exposure of its group members; which

is chartered and licensed as a liability insurance company and is authorized to engage in the business of insurance under the laws of any state, or prior to January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands, and before that date, certified to the commissioner of insurance, or other appropriate official, of at least one state that it satisfied the capitalization requirements of that state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since that date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability, as defined in the Federal "Product Liability Risk Retention Act of 1981," Pub. L. 97-45 (15 U.S.C. §3901 et seq.), before October 27, 1986; which does not exclude any person from membership in the group solely to provide for members of that group a competitive advantage over such a person; which has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group, or has as its sole owner an organization which has as its members only persons who comprise the membership of the risk retention group and its owners are the only persons who comprise the membership of the risk retention group and who are provided insurance by such group; whose members are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; whose activities do not include the provision of insurance, other than liability insurance for assuming and spreading all or any portion of the liability of its group members, and reinsurance with respect to the similar or related liability exposure of any other risk retention group, or any member of any other group, which is engaged in businesses or activities so that this group or member meets the requirement that members are engaged in businesses or activities similar or related with respect to the liability to which those members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations for membership in the risk retention group which provides the reinsurance; and the name of which includes the phrase "risk retention group."

11:2-36.3 Risk retention group registration requirements

(a) No risk retention group shall do business in this State as a risk retention group until it has complied with the requirements of this subchapter and received Notice of Registration from the Department.

(b) Any risk retention group which is chartered and licensed under the laws of any other state and which wishes to do business in this State shall submit to the Department.

1. A copy of its certificate of authority or license authorizing it to transact business as an insurance company, certified by the state of domicile;

2. A statement identifying the state(s) in which the risk retention group is chartered and licensed as a liability insurance company, the date of its charter and admission as a licensed insurer and its principal place of business, and any other information, including information regarding its membership. Additionally, the statement shall include the following:

i. The identity of those individuals who organized the group or who will provide administrative services or otherwise influence or control the activities of the group;

ii. The amount and nature of initial capitalization;

iii. The coverages to be afforded; and

iv. The states in which the group intends to operate;

3. A copy of its plan of operation or a feasibility study and revisions of such plan or study submitted to the state or states in which the risk retention is chartered and licensed in accordance with P.L. 1993, c.240;

4. A statement of registration (as set forth in Appendix A and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix B and incorporated herein by reference), which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process; and

5. Payment of the $100.00 registration filing fee which shall accompany the statement of registration, in accordance with N.J.A.C. 11:1-32.

(c) Any risk retention group currently registered with the Department prior to August 16, 1993 shall submit a statement of registration (as set forth in Appendix A) and a Notice of Appointment (as set forth in Appendix B). The registration must be filed no later than November 8, 1993. The risk retention group shall notify the Department of any change in the information in the statement of registration within 30 days of any change.

(d) Each foreign and alien risk retention group which has received a certificate of registration from the Department to do business in this State shall submit to the Department:

1. On or before March 1, or as prescribed by the state of domicile, a statement of financial condition for the proceeding calendar year ended December 31. The statement shall be on a form as prescribed by the state of domicile;

2. On or before June 1, a statement of opinion on loss or loss adjustment expense reserves made by a member of the American Academy of Actuaries, or a qualified loss reserve specialist;

3. By June 30, a report of financial condition, certified by an independent public accountant;

4. Within 30 days after filing in its state of domicile, a copy of each examination of the risk retention group as certified by the chartering state's commissioner or public official conducting the examination;

5. Upon request of the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

6. Such information as may be required to verify its continuing qualification as a risk retention group under N.J.A.C. 11:2-36.2, including, but not limited to*[:

i. A listing of all members participating in the risk retention group, and]**,* a certification of an officer that the group is composed of members whose business or activities are similar or related with respect to liability; and

7. Payment of the $100.00 Annual Statement filing fee in accordance with N.J.A.C. 11:1-32.

(e) Failure by any currently registered risk retention group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration may result in suspension or forfeiture of the risk retention group's registration status with the Department.

(f) Any person wishing to establish a risk retention group chartered and licensed to write only liability insurance in this State shall, in addition to meeting the requirements pursuant to N.J.S.A. 17:17-1 et seq., submit to the Department a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within 10 days of any such change. The group shall not offer any additional kinds of liability insurance in this State, or in any other state, until a revision of such plan or study is approved by the Commissioner. Additionally, the risk retention group shall adhere to the requirements of P.L. 1993, c.240 and (b)1 through 5 above.

(g) Each risk retention group, its agents and representatives shall comply with the Unfair Claims Settlement Practices Act of this State, N.J.S.A. 17:29B-1 et seq., and any other State law regarding deceptive, false or fraudulent acts or practices.

(h) Each risk retention group must submit to an examination by the Commissioner to determine its financial condition if the commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within 60 days after a request by the Commissioner of this State. The risk retention group shall pay the reasonable expenses of such an examination upon presentation by the Commissioner of a detailed account of the expenses.

(i) Each risk retention group shall comply with any lawful order issued in a voluntary dissolution proceeding or in a delinquency

proceeding commenced by the Commissioner if there has been a finding of financial impairment after an examination pursuant to this section.

(j) Each risk retention group shall comply with any injunction issued by a court of competent jurisdiction upon a petition by the Commissioner alleging that the group is in a hazardous financial condition or is financially impaired.

11:2-36.4 Additional risk retention groups requirements

(a) Any risk retention group which is registered in this State and chartered and licensed under the laws of any other state and which wishes to do business in this State, in addition to the requirements of N.J.A.C. 11:2-36.3, shall distribute its annual statement of operations to its members.

11:2-36.5 Notice and registration requirements of purchasing groups

(a) No purchasing group shall do business in this State as a purchasing group until it has complied with the requirements of this subchapter and received notification from the Department that it has been registered to do business in this State.

(b) Any group of persons with similar exposure to risk may form a purchasing group for the purpose of purchasing liability insurance.

1. Any purchasing group with members located in this State shall submit to the Department a statement of registration (as set forth in Appendix C and incorporated herein by reference) and a Notice of Appointment (as set forth in Appendix D and incorporated herein by reference) which shall be accompanied by a registration fee in accordance with N.J.A.C. 11:1-32.

2. Each purchasing group registered pursuant to this section shall submit to the Department from time to time, as it may require, reports relative to the group's operations.

3. Each purchasing group with members in this State registered pursuant to this subsection is subject to audits or examination as the Commissioner may deem necessary.

(c) Any purchasing group which was doing business in this State prior to August 16, 1993 shall submit to the Department a statement of registration (as set forth in Appendix C) and a Notice of Appointment (as set forth in Appendix D). The statement of registration must be filed no later than November 8, 1993. The purchasing group shall notify the Commissioner of any change in the information in the statement of registration within 30 days of any change.

(d) Failure of any currently registered purchasing group either to file a statement of registration, to complete all information requested pursuant to this subchapter or to update changes in the statement of registration, may result in suspension or forfeiture of the purchasing group's registration status with the Department.

11:2-36.6 Fines and penalties

(a) Each risk retention group, whether chartered in this State or otherwise, is subject to the same fines and penalties to which insurers licensed in this State are subject for any violation of this subchapter or any other applicable law.

(b) Failure of a risk retention group or purchasing group doing business in this State to comply with the provisions of this section may, after notice and a hearing 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, result in the revocation or suspension of its registration in this State.

APPENDIX A

STATEMENT OF REGISTRATION
STATE OF NEW JERSEY

APPLICATION FOR REGISTRATION AS
A RISK RETENTION GROUP
(All information should be typed)

1. List the corporate name of the Risk Retention Group.

_____

(Name *must* include the phrase "Risk Retention Group")

2. The Risk Retention Group is chartered and licensed as a liability insurance company under the laws of the State of _____, and is authorized to engage in the following lines of insurance under the laws of its chartering State:

_____

_____

_____

3. Ownership of the Risk Retention Group consists of one of the following (check one):

☐ the owners of the Group are the only persons who comprise the membership of the Group and who are provided insurance by the Group;

☐ The sole owner of the Group is_____

_____

_____

(Give name and address of organization)

an organization whose members only comprise the membership of the Group, and whose owners are only persons who comprise the membership of the Group and who are provided insurance by the Group.

4. Give a general description of business or activities engaged in by Group members:

_____

_____

_____

5. List the name, address, fax number and telephone number of each officer of the Risk Retention Group and the key officer or staff person (*Not* an employee of the group's management company) responsible for overseeing "hands on management" of the group. (Attach additional pages if necessary.)

_____

_____

_____

_____

6. A. List the home office address of the Risk Retention Group:

_____

_____

_____

B. List the mailing address of the Risk Retention Group:

_____

_____

_____

7. List the name, address and telephone number of the company responsible for management of the insurance operations of this risk retention group. (If none, answer none.)

_____

_____

_____

_____

8. List the name, address and telephone number of the principal agent or broker responsible for marketing the group's insurance policies, pursuant to N.J.S.A. 17:22A-1 et seq.

Name:_____

Address:_____

Phone Number:_____

Producer ID Reference Number:_____

9. The items described below should be attached to the registration form:

A. If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey General Treasury."

B. Completed and signed Service of Process.

C. A listing of the individual(s) who organized the group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.

[D. A listing of current members.]

As President or Chief Executive Officer of the _____, I hereby certify that the information contained in this registration is true and correct and in conformance with 15 USC 3901 et seq., N.J.S.A. 17: _____ and N.J.A.C. 11: _____. Further, I certify that:

The Risk Retention Group is composed of members who are engaged in the following described business or activities, which are similar or related with respect to the liability to which such members are exposed by virtue of related, similar, or common business, trade, product, services, premises or operations.

The primary activity of this Risk Retention Group consists of assuming and spreading all, or any portion, of the liability exposure of its members.

The Risk Retention Group is organized for the primary purpose of conducting the activity described above.

The Risk Retention Group does not exclude any person from membership in the Group solely to provide for members of the Group a competitive advantage over such a person.

The activities of the Risk Retention Group do not include the provision of insurance other than:

(a) Liability insurance for assuming and spreading all or any portion of the similar or related liability exposure of its Group members; and

(b) Reinsurance with respect to the similar or related liability exposure of another Risk Retention Group (or a member of such other Risk Retention Group) engaged in business or activities which qualify such other Risk Retention Group (or member) under item (6) above for membership in this Group.

In addition all required documents as set forth in 15 USC 3901 et seq., N.J.S.A. 17:_____ and N.J.A.C. 11:_____ are being included in this filing.

_____
President or Chief Executive Officer

_____
Secretary

Sworn before me this_____

day of_____,

19_____.

_____
Notary Public, State of:
My Commission Expires:

(Revised 7/93)

APPENDIX B

NOTICE OF APPOINTMENT OF
ATTORNEY TO ACCEPT SERVICE

STATE OF _____
DEPARTMENT OF INSURANCE

The_____, a Risk Retention Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors, full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed at the City of _____, State of _____, this _____ day of _____, 19_____.

Attest:

_____ _____
Secretary (Name of Risk Retention Group)

By

_____
President

(Revised 7/93)

APPENDIX C

STATE OF NEW JERSEY
APPLICATION FOR REGISTRATION
AS A PURCHASING GROUP
(All information should be typed)

1. List the exact name of the Purchasing Group.

2. Indicate the form of organization or incorporation and date.

3. The Purchasing Group is domiciled in the State of:

4. List any other names under which the Purchasing Group is or may be doing business in this State or any other State if different from above.

5A. List the complete physical address of the Purchasing Group.

5B. List the mailing address of the Purchasing Group.

6A. List the name, title, address, fax number, and telephone number of the principal officer of the purchasing group who has knowledge of its insurance program, including membership criteria, coverages, and key personnel of the group's administrator and insurance carrier.

6B. List the name, title, address, fax number, and telephone number of the firm that acts as the administrator of the purchasing group and the name of the principal account executive responsible for the group's insurance program. (If none, answer none.)

7. List the names, addresses and occupation of the principal officers and directors of the Purchasing Group. Attach additional pages if necessary.

Principal Officers	Principal Directors

8. Give a general description of the business or activities engaged in by purchasing group members:

9. List the lines and classification of liability insurance Purchasing Group will purchase:

10. What are the limits of liability including per occurrence, aggregate per participant and group aggregate.

11. Deductible and self-insurance retentions

(a) Which are the responsibility of the individual participant?

(b) Which are the responsibility of the purchasing group and how funded?

12. List the insurance carriers from whom the Purchasing Group will purchase liability insurance described in item (9) above from. Give full name of company, state of domicile and NAIC#:

13. Purchasing groups procuring insurance through companies licensed in New Jersey or registered Risk Retention Groups must use an insurance producer pursuant to N.J.S.A. 17:22A-1 et seq. Please identify the producer(s) representing the purchasing group:

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

14. Purchasing groups procuring insurance from New Jersey eligible surplus lines companies must place it through a licensed New Jersey insurance producer with surplus lines authority pursuant to N.J.S.A. 17:22-6.40 et seq. and 17:22A-1. Please identify the producer(s) representing the purchasing group:

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

15. List who will adjust the claims?

Name_____

Address_____

Phone No._____

Producer License Reference Number: _____

16. Has any person transacting business on behalf of this Purchasing Group ever:

(A) been arrested, indicted and convicted of a felony or is a felony charge currently pending against any such person? _____

(B) had denied any application for a professional, vocational or business license? _____

(C) has suspended or revoked any such license? _____

(D) had withdrawn or surrendered any such application or license to avoid potential disciplinary action against licensee? _____

If the answer to any part of this question is yes, attach a supplementary statement explaining in full each such occurrence.

The items described below should be attached to the registration form:

(a) If not previously submitted, registration fee in the amount of $100.00 made payable to the "State of New Jersey—General Treasury."

(b) Completed and signed Service of Process.

(c) A listing of the individual(s) who organized the Purchasing Group and the individuals who are providing administrative services or otherwise influence or control the activities of the group.

(d) A listing of current members.

- The Purchasing Group is composed of members whose business or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar, or common business, trade, product, services, premises or operations.
- The Purchasing Group purchases such liability insurance only for its members and only to cover their similar or related liability exposure, as described in item (8) above.
- The policy and promotional material the purchasing group will use has been forwarded along with the registration.

In addition, all required documents are set forth in 15 USC 3901 et seq., N.J.S.A. 17: _____ and N.J.A.C. 11: _____ are being included in this filing.

_____
President or Chief Executive Officer

_____
Secretary

Sworn before me this_____
day of_____,
19_____.

_____
Notary Public, State of:
My Commission Expires:

(Revised 7/93)

APPENDIX D

NOTICE TO APPOINTMENT OF ATTORNEY TO ACCEPT SERVICE

STATE OF NEW JERSEY

The_____, a *[Risk Retention]* ***Purchasing*** Group (called the Group) duly organized under the laws of the State of _____, appoints the Insurance Commissioner of the State of _____, and his or her successors in office, to be its lawful attorney upon whom all legal process in any action or proceeding against it shall be served and further agrees that any lawful process against it which is served upon this attorney shall have the same legal validity as if served personally upon the Group.

The Group gives the Insurance Commissioner and his or her successors full authority to do every act necessary to be done under this appointment as fully as the Group could do if personally present, and ratifies all that lawfully do under the power granted by this appointment. This authority may be withdrawn only upon a written notice of revocation and in any case shall continue in effect so long as any liability arising out of this appointment remains outstanding in the State. This constitutes full compliance with Section 2(a)(1)(D) of the Liability Risk Retention Act of 1986.

The Group designates [_____] whose address is [_____] as the person to whom process against the Group served upon the Commissioner [Director, Superintendent] shall be forwarded.

IN WITNESS OF THIS APPOINTMENT, said Group pursuant to a resolution duly adopted by its Board of Directors, has caused this instrument to be executed in its name by its President and Secretary, and its corporate seal to be affixed in the City of _____, State of _____, this _____ day of _____, 19_____.

Attest:

_____ _____
Secretary (Name of Risk Retention Group)

By

_____
President

(a)

DIVISION OF FINANCIAL EXAMINATIONS AND LIQUIDATIONS

Producer-Controlled Insurers

Adopted Concurrent New Rules: N.J.A.C. 11:2-37

Proposed: September 7, 1993 at 25 N.J.R. 4304(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.559, **without change.**

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e), and P.L. 1993, c.239.

Effective Date: October 15, 1993.
Expiration Date: November 30, 1995.

These rules were adopted on an emergency basis and concurrently proposed on September 7, 1993, pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed new rules is effective upon acceptance for filing at the Office of Administrative Law. See N.J.A.C. 1:30-4.4(d).

Summary of Public Comments and Agency Responses:

The Department received one comment from the American Insurance Association. The commenter questioned whether the Department had the statutory authority to require all insurers, not just producer-controlled insurers, to file an annual Producer-Controlled Insurer Information Report with the Commissioner. Additionally, the commenter sug-

gested that the scope of information that must be contained in the certification filed by producer-controlled insurers exceeded statutory authority.

RESPONSE: Insurers that are not producer-controlled are only required to certify that they are not producer-controlled.

N.J.A.C. 11:2-37.5(a)2. The Department believes that the authority to elicit such a representation from insurers is implied in the underlying statute. This requirement provides the Department with the means of assuring that **all** insurers have at least considered whether they are producer-controlled and therefore subject to the more detailed filing requirements. Furthermore, the Department believes that the scope of information required to be filed annually by producer-controlled insurers is entirely consistent with the statutory requirements.

Full text of the adoption follows:

SUBCHAPTER 37. PRODUCER-CONTROLLED INSURERS

11:2-37.1 Purpose

The purpose of this subchapter is to implement P.L. 1993, c.239 to enable the Department to regulate transactions involving insurers which are controlled by insurance producers.

11:2-37.2 Scope

This subchapter shall apply to all licensed property and casualty insurers domiciled in this State or domiciled in a state that is not an accredited state having in effect a law substantially similar to P.L. 1993, c.239. This subchapter shall not apply to captive insurers.

11:2-37.3 Definitions

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

"Accredited state" means a state in which the insurance department or other regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the NAIC.

"Captive insurer" means an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations or group members and their affiliates.

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

"Control" or "controlled" has the same meaning as defined at N.J.S.A. 17:27A-1c.

"Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

"Controlling producer" means a producer who, directly or indirectly, controls an insurer.

"Department" means the New Jersey Department of Insurance.

"Licensed insurer" or "insurer" means any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1.

"NAIC" means National Association of Insurance Commissioners.

"Producer" means any person engaged in the business of an insurance agent, insurance broker or insurance consultant as defined at N.J.S.A. 17:22A-2.

"Producer-controlled" means controlled, directly or indirectly, by a producer.

11:2-37.4 Filing of Producer-Controlled Insurer Information Report

All licensed property and casualty insurers domiciled in this State or domiciled in another state that is not an NAIC accredited state having in effect a law substantially similar to P.L. 1993, c.239, shall file an annual Producer-Controlled Insurer Information Report on a form (incorporated herein by reference as Appendix A) approved by the Commissioner. The Report shall be completed and filed with the Commissioner on or before April 1 for the calendar year immediately preceding.

11:2-37.5 Contents of the Producer-Controlled Insurer Information Report

(a) A Producer-Controlled Insurer Information Report form (Appendix A) shall be completed annually by each licensed property and casualty insurer to whom this subchapter applies and shall include the following information:

1. The name and address of the reporting insurer and any controlling producer. (A separate form should be completed and filed for each controlling producer.);

2. A certification by insurers that are not producer-controlled that they are not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c.239 or this subchapter;

3. A certification by producer-controlled insurers containing the following information:

i. The amount of the insurer's admitted assets as of September 30 of the preceding calendar year, gross premiums written during the calendar year and the percentage that gross premiums written represent of admitted assets;

ii. The amount of net premiums written during the preceding calendar year, commissions paid to the controlling producer during the calendar year and the percentage that commissions paid to the controlling producer represent of the net premiums written;

iii. Comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance;

iv. An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer, which loss reserve opinion shall satisfy all requirements established by N.J.A.C. 11:1-21 for loss reserve opinions required to be submitted by licensed property and casualty insurers in this State; and

v. A statement indicating whether or not the insurer's controlling producer or producers have been notified of the requirements of P.L. 1993, c.239 and these rules.

11:2-37.6 Confidentiality of documents

All documents submitted to the Commissioner pursuant to this subchapter are confidential and not public documents as defined in the Public Records Act, N.J.S.A. 47:1A-1 et seq.

11:2-37.7 Penalties

Failure to comply with the provisions of this subchapter may result in the imposition of penalties as provided by law.

APPENDIX A

PRODUCER-CONTROLLED INSURER INFORMATION REPORT FORM

Calendar Year Ending December 31, _____

Instructions: All licensed property and casualty insurers domiciled in New Jersey, or domiciled in another state that is not a NAIC "accredited state" having in effect a law substantially similar to P.L. 1993, c.239, are required to complete annually either Section I or Section II of this form. Section I certifies that the requirements of New Jersey Law have been reviewed and there is no controlling producer information to be reported. Section II should be completed for each producer who "controls" a reporting insurer. Completed reporting forms are due annually, on or before April 1 of each year.

SECTION I
To be completed by Insurers that are *not* Producer-Controlled

I certify that_____
(Name of Insurer)

_____
(Address of Insurer)

is not issuing any property and casualty insurance coverages that are or may be reportable pursuant to the provisions of P.L. 1993, c.239 and N.J.A.C. 11:2-37.1 et seq.

_____ _____
Date Authorized signature

_____
Title

SECTION II
To be completed by Producer-Controlled Insurers

(A separate Report Form should be completed and filed for each controlling producer.)

Calendar Year Ending December 31, _____

Name of Reporting Insurer: _____

Address: _____

Name of Controlling Producer: _____

Address: _____

1. Insurer's admitted assets as of September 30 of calendar year pursuant to P.L. 1993, c.239, §3a: $_____
2. Gross premiums written, calendar year: $_____
3. Percentage that gross premiums written represent of admitted assets: _____ %
4. Net premiums written, calendar year: $_____
5. Amount of commissions paid to controlling producer, calendar year: $_____
6. Percentage that commissions paid represent of net premiums written: _____ %
7. Comparable amounts and percentage paid to noncontrolling producers for placement of the same kinds of insurance:
   Net premiums written: $_____
   Commissions paid: $_____
   Percentage: _____ %
8. Attach the information required by P.L. 1993, c.239, § 3e: An opinion of an independent casualty actuary reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end, including losses incurred but not reported, on business placed by the controlling producer.
9. We have notified our controlling producer(s) of the requirements of P.L. 1993, c.239 and N.J.A.C. 11:2-37.1 et seq.

I certify that the above information is accurate and complete.

_____ _____
Date Authorized signature

_____
Title

(a)

DIVISION OF FINANCIAL EXAMINATIONS

Increase in Property and Casualty Capital and Surplus Requirements

Adopted Rules: N.J.A.C. 11:2-38

Proposed: September 7, 1993 at 25 N.J.R. 4306(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.560, **with substantive and technical changes** not requiring additional public comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e), 17:17-1 et seq., and 17:50-5.

Effective Date: October 15, 1993, Readoption of emergency new rules;
November 15, 1993, Changes upon adoption.
Expiration Date: November 30, 1995.

These new rules were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for changes upon adoption, which are effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

The Department received a total of six comments on the proposed rules from the following: Mercer Mutual Insurance Company; certain members of the Chubb Group of Insurance Companies (Chubb Custom Insurance Company, Chubb Insurance Company of New Jersey, Federal Insurance Company, Great Northern Insurance Company, Vigilant Insurance Company, and Pacific Indemnity Company); State Farm (State Farm Fire and Casualty Company and State Farm General Insurance Company); Royal Insurance; American Insurance Association; and New Jersey Association of Mutual Insurance Companies.

COMMENT: The Department received several comments on the proposed definitions of "capital" and "surplus." One commenter requested a clarification of the proposed rule's definitions of "capital" and "surplus" for purposes of meeting the minimum requirements as set forth at N.J.S.A. 17:17-6. Specifically, one commenter questioned whether surplus is to be represented in Line 24A, Page 3 of the Annual Statement ("Gross paid in and contributed surplus"), or rather, is to be determined by subtracting minimum capital (that is, number of shares times par value) from Line 25, Page 3 of the Annual Statement ("Surplus as regards policyholders"). Another commenter suggested that the Department review its proposed definitions of "capital" and "surplus" and references to "net worth" as reported in the Annual Statement because New Jersey's definitions (in both its laws and regulations) are ambiguous and differ greatly from other states, particularly the "net worth" term. Another commenter stated that the proposed definition of "surplus" as respects a stock insurer seems to imply that surplus means the combined total of both paid-in and unassigned surplus.

RESPONSE: In response to the first commenter, surplus is to be determined by subtracting minimum capital from Line 25, Page 3 of the Annual Statement ("Surplus as regards policyholders"). In response to the second commenter, the Department defines "net worth" as surplus as regards policyholders, which is represented on Line 25, Page 3 of the Annual Statement. Finally, the Department agrees with the comment that the rule's proposed definition of "surplus" as respects a stock insurer means the combined total of both paid-in and unassigned surplus.

COMMENT: One commenter stated that the proposed definition of "capital" fails to recognize that some states (for example, Illinois and Alaska) bar dividend distributions from certain surplus of a stock insurer, and that the proposed rule should recognize that "surplus" that is unavailable for dividends of any kind can be considered to be capital stock for the purposes of meeting the statutory minimum capital requirements. The commenter suggested that the proposed definition of "capital" be amended by adding the following language: Capital also includes surplus that is unavailable for dividends of any kind.

RESPONSE: The Department disagrees with the commenter's suggestion. Surplus cannot be construed to be capital stock. N.J.S.A. 17:17-8 requires the Department prior to issuing a certificate of authority, to ensure that "the whole amount of the capital stock set forth in the

certificate of incorporation and the required minimum surplus of the company, if a stock company, has been actually paid in cash, and is possessed by the company in money, or in the stocks, bonds, or bonds and mortgages . . .[.]"

COMMENT: Another commenter stated that the proposed definition of "capital" would cause insurers to either change the par value of the common stock or issue additional shares, requiring action by the board of directors. The commenter continued that because some insurers are not yet aware that such action is necessary, the date for requesting waivers from meeting the statutory capital and surplus requirements should be extended until December 31, 1993.

RESPONSE: The Department disagrees. Under these rules, all temporary waivers are to be requested by October 8, 1993, and all financial plans are to be filed with the Department by February 8, 1994. By way of emergent adoption of these rules, the Department notified all insurers in early September to request a temporary waiver of the statutory capital and surplus requirements or file a certification of compliance. If the Department determined upon review of the insurer's submission of a certification of compliance that the insurer's calculation of capital and/or surplus may be mistaken, the Department has notified the insurer in writing that it should immediately request a temporary waiver. The insurer's financial plan is then expected to be filed by February 8, 1994, or within a reasonable time thereafter. The Department intends to continue this practice.

COMMENT: One commenter stated that the proposed definition of "capital" may be inconsistent with the underlying statute in that N.J.S.A. 17:17-4(e) requires that par value per share shall not be less than $1.00, thereby prohibiting no par shares.

RESPONSE: The proposed definition of "capital" is not inconsistent with N.J.S.A. 17:17-4(e). Rather, it is broad enough to include foreign insurers admitted in New Jersey, which are permitted to issue shares with a par value less than $1.00.

COMMENT: One commenter expressed its concern about the proposed definition of "current surplus/capital" to be included in an insurer's financial plans required to be submitted to the Department under N.J.A.C. 11:2-38.3(c)1. The commenter stated that capital and surplus change daily, and suggested that this proposed requirement refer back to the last filed quarterly statement or the levels in effect at the end of the previous calendar month.

RESPONSE: The Department intended that "current surplus capital" to be included in the insurer's proposed financial plan required to be submitted to the Department under N.J.A.C. 11:2-38.3(c)1 be obtained from the insurer's last filed quarterly statement. Accordingly, the Department is revising the rule to that effect.

COMMENT: A few of the comments were in regard to the proposed requirement at N.J.A.C. 11:2-38.3 that insurers requesting a two-year waiver from compliance with the statutory minimum capital and surplus requirements file a five-year financial projection with the Department within 120 days of applying for a waiver. Some commenters stated that this requirement should not apply to those insurers whose combined total capital and surplus meet or exceed the total of the statutory capital and surplus requirements. According to the commenters, these insurers would be able to meet the statutory requirements within 120 days merely by making various corporate and accounting adjustments to either capital stock or surplus accounts (for example; issuing stock so as to transfer surplus to its capital account without changing total net worth; eliminating lines of insurance which the insurer does not use, thereby reducing its capital requirements).

RESPONSE: The Department agrees that it would be unnecessary for an insurer to file a detailed financial plan under the circumstances described by the commenter. In such instances the Department believes that it would be more appropriate for an insurer to file only a limited financial plan, and has added language at N.J.A.C. 11:2-38.3(c)7 to this effect.

COMMENT: One of the commenters suggested that language be included in the rule exempting from compliance with the procedures at N.J.A.C. 11:2-38.3(c) through (f) those insurers meeting the statutory capital and surplus requirements within 120 days of filing for a temporary waiver, or filing with the Commissioner within 120 days a plan of orderly withdrawal pursuant to N.J.A.C. 11:2-29 to delete unused lines of insurance from its license.

RESPONSE: The Department agrees that it would be unnecessary for an insurer to submit a financial plan to the Department if the insurer meets the statutory capital and surplus requirements in the 120-day period between applying for a temporary waiver of the statutory requirements and submitting a financial plan to the Department. In such an instance, the insurer need only file with the Department a certification that it has met the capital and surplus requirements. Accordingly, the Department has added language to N.J.A.C. 11:2-38.3(i) to this effect. If an insurer intends to meet the statutory capital and surplus requirements by deleting unused lines of insurance, the insurer would still be required to file a limited financial plan as described in revised N.J.A.C. 11:2-38.3(c)7ii, but may request a waiver from filing a plan of orderly withdrawal. If a waiver from filing a plan of orderly withdrawal is not requested, the insurer is required to comply with the withdrawal requirements set forth at N.J.A.C. 11:2-29.

COMMENT: One commenter stated that N.J.A.C. 11:2-38.3(a) fails to set forth what constitutes making an "application" to the Department for a temporary waiver of capital and surplus requirements, and fails to include a requirement that the Department acknowledge receipt of a waiver request.

RESPONSE: An application for a temporary waiver from the minimum statutory capital and surplus requirement consists of a written request from the insurer to the Department for such a waiver. The proposed rules further require such an insurer to file a financial plan with the Department within 120 days of applying for a temporary waiver. Upon receipt of the financial plan, N.J.A.C. 11:2-38.3(d) requires the Department to notify the insurer in writing of its approval of or deficiencies in the plan. Such notice serves as an acknowledgement that the Department has received the insurer's temporary waiver request and financial plan.

COMMENT: One commenter stated that the difficulty in filing a five-year projection as required by N.J.A.C. 11:2-38.3 and 38.4 will have a chilling effect on the filing of a financial plan. The commenter suggested a three-year financial projection instead, which tracks a "business plan" rule in effect in several states for newly-licensed companies.

RESPONSE: The Department disagrees. By requiring that a five-year financial projection be included in an insurer's financial plan to be submitted to the Department, the insurer is provided with a five-year period within which to comply with the statutory capital and surplus requirements. Additionally, New Jersey requires newly-organized companies to provide the Department with a five-year financial projection.

COMMENT: One commenter stated that N.J.A.C. 11:2-38.3(c)5 will grant the Commissioner unfettered discretion to require any and all types of documentation, projections and the like.

RESPONSE: The Department disagrees. This proposed provision requires, in addition to the specific items to be submitted with a proposed financial plan to the Department, to also submit "any other information requested by the Commissioner which is relevant to the evaluation of a specific temporary waiver request." The specificity of this language precludes the Commissioner from exercising unfettered discretion in requesting that insurers submit any and all types of documents.

COMMENT: One commenter stated that N.J.A.C. 11:2-38.3(d) fails to provide any outward period by which the Commissioner is to notify an insurer as to whether a financial plan has been approved, and suggested a period of 30 days after filing.

RESPONSE: The Department appreciates the commenter's concern that the rules include a time period within which the Department shall provide notice to the insurer concerning the adequacy of its financial plan. However, the Department believes that it will be impossible to comply with a 30-day notice period given the number of financial plans expected to be submitted and requiring review by Department staff. Accordingly, the Department has intentionally excluded any such time period from the rules, but expects to review the financial plans as expeditiously as possible.

COMMENT: One commenter stated that the requirement at proposed N.J.A.C. 11:2-38.4(b) that an insurer respond to the Commissioner's order to increase capital and surplus within seven days of receipt of the order is too short a time frame, and suggested a 14-day response period instead. The same commenter requested that the requirement at proposed N.J.A.C. 11:2-38.5 that insurers request a hearing within seven days of receipt of the Commissioner's order issued pursuant to N.J.A.C. 11:2-38.4 be changed to allow an insurer 14 days to request a hearing.

RESPONSE: P.L. 1993, c.234, section 6 requires that a formal departmental hearing concerning an increase in capital or surplus requirements be initiated within 20 days after the Commissioner notifies an insurer that an increase is required. Given that short time frame, it would be impractical to allow an insurer 14 days before even notifying the Commissioner that it is requesting a hearing. Additionally, if an insurer is responding to the Commissioner's order pursuant to the requirements

at N.J.A.C. 11:2-38.4(b) (that is, waiving its right to a hearing and notifying the Department that it will submit a proposed plan within 60 days for meeting the capital and surplus requirements), it is the Department's position that the requirements are not so onerous to preclude an insurer from filing the response within seven days.

Summary of Changes Upon Adoption:

1. N.J.A.C. 11:2-38.3(c) has been revised to include language that 11:2-38.3(c)7 and 38.3(i) provide certain exceptions to the requirements set forth at (c)1 through 6 for insurers applying for a temporary waiver of the statutory minimum capital and surplus requirements.

2. N.J.A.C. 11:2-38.3(c)1 has been revised to add language clarifying that the current surplus/capital to be included on an insurer's proposed financial plan is to be obtained from the insurer's last filed quarterly statement.

3. N.J.A.C. 11:2-38.3(c)7 has been added, which permits certain insurers who intend to meet the statutory capital and surplus requirements, either by completing certain corporate and/or accounting adjustments to either capital stock or surplus accounts or by deleting unused lines of business, to file with the Department a limited financial plan instead of the more detailed financial plan required under N.J.A.C. 11:2-38.3(c)1 through 6.

4. N.J.A.C. 11:2-38.3(i) has been added, which permits an insurer requesting a temporary waiver under N.J.A.C. 11:2-38.3(a) through (f), but meeting the statutory minimum capital and surplus prior to expiration of the 120-day period for filing a financial plan with the Department, to file a certification that it has met the requirements instead of filing a financial plan.

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

SUBCHAPTER 38. INCREASE IN PROPERTY AND CASUALTY CAPITAL AND SURPLUS REQUIREMENTS

11:2-38.1 Purpose and scope

(a) The purpose of this subchapter is to provide procedures whereby property and casualty insurers may request a temporary waiver from the minimum capital and surplus requirements set forth in P.L. 1993, c.234, sections 2 and 3. This subchapter also provides procedures whereby the Commissioner may, pursuant to P.L. 1993, c.234, section 6, subsequently require an increase in these statutory minimum requirements.

(b) This subchapter shall apply to all insurers, including reciprocal insurance exchanges, authorized, admitted or eligible to transact the business of property and casualty insurance in this State.

11:2-38.2 Definitions

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

"Capital" means par value per share multiplied by the number of issued shares, or in the case of no-par shares, the total stated value.

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

"Department" means the New Jersey Department of Insurance.

"Insurer" means any stock or mutual insurance corporation, including a reciprocal insurance exchange, authorized, admitted or eligible to transact the business of property and casualty insurance in this State pursuant to N.J.S.A. 17:17-1 et seq.

"Surplus" means the net worth of an insurer as reported in its annual statement. For a stock insurer, surplus means net worth less minimum capital. For a mutual insurer, surplus means its net worth.

11:2-38.3 Requests for temporary waiver of capital and surplus requirements

(a) An insurer transacting business in this State as of August 9, 1993 may request a two-year temporary waiver from the minimum capital and surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3, by making application in writing to the Commissioner on or before October 8, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Exams, Capital and Surplus Waivers
20 W. State Street
CN 325
Trenton, NJ 08625

(b) The Commissioner shall approve a temporary waiver requested pursuant to (a) above provided the insurer complies with the requirements set forth in (c) through (f).

(c) *[Within]* ***With the exception of (c)7 and (i) below, within**** 120 days of making application to the Commissioner for a temporary waiver of the statutory minimum capital and surplus requirements, the insurer shall additionally submit to the Department at the same address as set forth in (a) above, a proposed financial plan, which shall include the following:

1. The insurer's current capital and/or surplus ***as reflected in the last filed quarterly statement***;

2. The reason(s) for the insurer's inability to meet the minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3;

3. The insurer's proposed method and time frame for meeting the statutory minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding;

4. A five-year projection, beginning December 31 of the following year and for the subsequent four years, of the following certified by a qualified actuary and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of businesss for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred; and

(4) Ratios of the sum of the losses and loss expenses to premium earned;

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

5. Any other information requested by the Commissioner which is relevant to the evaluation of a specific temporary waiver request.

6. In the case of a request for an extension pursuant to (g) below of a two-year waiver granted under (b) above, the insurer's proposed financial plan shall additionally include a report of the insurer's progress in meeting the minimum capital and/or surplus requirements.

***7. Certain insurers transacting business in this State as of August 9, 1993 may, instead of filing the financial plan pursuant to (c)1 through 6 above, file a limited financial plan with the Department as follows:**

i. Insurers intending to meet the statutory minimum capital and surplus requirements by deleting unused lines of business from its certificate of authority shall file within 120 days of making application to the Commissioner for a temporary waiver of the requirements, a limited financial plan which shall include a concise, accurate description of the specific course of action the insurer will follow to comply with the statutory capital and surplus requirements. These insurers may request in writing from the Commissioner a waiver from filing an orderly plan of withdrawal pursuant to N.J.A.C. 11:2-29.

ii. Insurers intending to meet the statutory minimum capital and surplus requirements by completing certain corporate and/or accounting adjustments to either capital stock or surplus accounts, shall file within 120 days of making application to the Commissioner

for a temporary waiver of the requirements, a limited financial plan which shall include a concise, accurate description of the specific course of action the insurer will follow to comply with the statutory capital and surplus requirements.*

(d) Upon receipt of the insurer's financial plan in (c) above, the Department shall provide the insurer with written notice of its approval of, or of any deficiencies in, the financial plan's proposed method for meeting the minimum capital and/or surplus requirements.

(e) Within 60 days of receipt of the Department's notice in (d) above informing the insurer of the deficiencies in its proposed financial plan, the insurer shall resubmit a revised financial plan correcting all deficiencies to the Department at the address set forth in (a) above.

(f) All data or information contained in the plan under (c) above is confidential and will not be disclosed by the Department to any person other than its employees and representatives.

(g) An insurer may request an extension of a two-year waiver granted by the Commissioner under (b) above not to exceed the five-year statutory compliance period set forth in P.L. 1993, c.234, sections 2 and 3 by submitting to the Department at least 90 days prior to the expiration of the two-year waiver, the items set forth in (c) above. The Department shall evaluate the insurer's extension request by following the procedures set forth in (d) through (f) above.

(h) If an insurer fails to request a temporary waiver of the minimum capital and/or surplus requirements pursuant to the procedures set forth in this section, the Department shall conclude that the insurer has met the minimum capital and/or surplus requirements. If, in fact, the insurer is unable to meet the minimum statutory capital and/or surplus requirements, the insurer shall be subject to suspension or revocation of its authority to do business in this State pursuant to P.L. 1993, c.234, section 9.

(i) An insurer filing for a temporary waiver of the statutory capital and surplus requirements pursuant to (a) through (f) above, but which meets the requirements prior to expiration of the 120-day period for filing a financial plan with the Department, shall not be required to file a financial plan with the Department pursuant to N.J.A.C. 11:2-38.3(c). The insurer shall be required to file with the Department, within 120 days of applying for a waiver, a certification signed by the insurer's Chief Executive Officer, stating that the insurer has met the statutory capital and surplus requirements. The Commissioner may request that the insurer submit additional documentation to support the certification, if necessary.

11:2-38.4 Procedures for increasing capital and surplus requirements

(a) If, upon consideration of the risks and factors set forth in P.L. 1993, c.234, sections 6 and 7, the Commissioner determines that an increase in an insurer's minimum capital and/or surplus requirements set forth at P.L. 1993, c.234, sections 2 and 3 is required to provide adequate protection against risks affecting the insurer's financial condition that are not adequately or fully covered by its reserves or other assets, the Commissioner shall notify the insurer as follows:

1. The Commissioner shall issue an order to insurer, which shall include the following:

i. The minimum amount of capital and surplus required;

ii. The amount by which the insurer's capital or surplus is deficient; and

iii. Notice that the insurer shall either submit a plan to the Commissioner for meeting its applicable capital and surplus requirements pursuant to (b) below or request a hearing pursuant to N.J.A.C. 11:2-38.5.

(b) With the exception of requesting a hearing pursuant to N.J.A.C. 11:2-38.5, the insurer shall respond to the Commissioner's order issued under (a) above within seven days from the date of receipt of such order as follows:

1. The insurer's response to the Commissioner's order shall be in writing and shall include:

i. A waiver of the insurer's right to a departmental hearing on the Commissioner's determination; and

ii. Notice that the insurer shall submit a proposed plan to the Commissioner within 60 days from Commissioner's receipt of insurer's response in (b) above for meeting the applicable increased capital or surplus requirements.

2. The insurer's plan for meeting the applicable capital and surplus requirements shall be in writing and shall include:

i. The insurer's proposed method and time frames for meeting the increased minimum capital and/or surplus requirements, including the source(s) and amount(s) of additional funding; and

ii. A five-year projection, beginning December 31 of the following year and for the subsequent four years, certified by a qualified actuary as defined at N.J.A.C. 11:1-21 and accompanied by a narrative explaining the sources of anticipated premium and all assumptions made in developing the entire projection.

3. The insurer's five-year projection shall include:

i. Assets, liabilities and surplus and other funds in the format of the Assets page and the Liabilities and Surplus and Other Funds page in the Annual Statement representing the insurer's five successive year-ends;

ii. Underwriting and investment income in the format of the Underwriting and Investment Exhibit, Statement of Income in the Annual Statement for each of the five years;

iii. The following information by line of business for each of the five years (the line of business classifications shall be those set forth in the Underwriting and Investment Exhibit, Part Two in the Annual Statement):

(1) Premiums earned;

(2) Losses incurred;

(3) Loss expenses incurred;

(4) Ratios of the sum of the losses and loss expenses to premium earned; and

(5) Net premiums written; and

iv. The projected values required in the Underwriting and Investment Exhibit, Part Four—Expenses in the Annual Statement; and

4. Any other information requested by the Commissioner which is relevant to the evaluation of the insurer's plan to comply with increased capital and surplus requirements.

(c) The Department shall, upon receipt of the insurer's proposed plan in accordance with N.J.A.C. 11:2-38.4(b), provide the insurer with written notice of its approval of, or any deficiencies in, the proposed plan.

11:2-38.5 Hearing requirements and procedures

(a) If an insurer is subject to an order issued by the Commissioner pursuant to N.J.A.C. 11:2-38.4(a), and the insurer objects to the actions ordered to be taken as set forth therein, the insurer may request a hearing on the Commissioner's determination within seven days from the date of receipt of such order as follows:

1. A request for a hearing shall be in writing and shall include:

i. The name, address, and daytime telephone number of a contact person familiar with the matter;

ii. A copy of the order involved;

iii. A statement requesting the hearing; and

iv. A concise statement specifying the reason(s) the insurer should not be required to increase its capital and surplus consistent with the Commissioner's order.

(b) Pursuant to P.L. 1993, c.234, section 6, a hearing relating to the increase of capital or surplus shall be a formal departmental hearing before the Commissioner or his deisgnee, on a record, and all matters pertaining to a hearing or to an increase of capital or surplus shall be confidential and not subject to subpoena or public inspection, except as otherwise provided by N.J.S.A. 17:17-1 et seq.

(c) The Department shall initiate the departmental hearing within 20 days from the date of the insurer's receipt of the Commissioner's notice in N.J.A.C. 11:2-38.4(a) above.

(d) An Order issued by the Department pursuant to N.J.A.C. 11:2-38.4(a) above shall be stayed pending the outcome of the hearing.

(e) The Department shall issue a written hearing decision within 30 days of the hearing, which shall include the Department's findings and a determination whether the Order issued in N.J.A.C. 11:2-38.4(a) above shall be affirmed, modified or rescinded.

11:2-38.6 Fines and penalties

(a) Failure to comply with this subchapter may result in an insurer's suspension or revocation of authority to do business in the State of New Jersey.

(a)

DIVISION OF FINANCIAL EXAMINATIONS AND LIQUIDATIONS

Increase in Capital and Surplus Requirements for Life and Health Insurers

Adopted Concurrent New Rules: N.J.A.C. 11:2-39

Proposed: September 7, 1993 at 25 N.J.R. 4309(a).

Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: October 15, 1993 as R.1993 d.561, **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. 17:1-8.1, 17:1C-6(e), 17:32-31 et seq., P.L. 1993, c.235 and c.245.

Effective Date: October 15, 1993, Readoption of emergency rules;
November 15, 1993, Change upon adoption.

Expiration Date: November 30, 1995.

These rules were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed new rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for change upon adoption which is effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:
No comments received.

Summary of Agency-Initiated Change:

The Department has added a new paragraph 4 at N.J.A.C. 11:2-39.15(a) in order to relieve insurers who have requested a temporary waiver of the minimum capital and surplus requirements from the necessity of filing an RBC Plan if they are able to certify that they meet the minimum requirements as of December 31, 1993. For some insurers (in particular, subsidiaries of larger corporations), the appropriate response to these new laws and rules will be to directly increase capital and/or surplus. If this is done promptly, the Department should not require and does not need to review an RBC Plan.

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

SUBCHAPTER 39. INCREASE IN CAPITAL AND SURPLUS REQUIREMENTS FOR LIFE AND HEALTH INSURERS

11:2-39.1 Purpose and scope

The purpose of this subchapter is to provide a framework for the establishment of uniform risk-based capital and surplus requirements for all insurers authorized to write life, health and annuity business specified in N.J.S.A. 17B:17-3, 4 and 5, and to implement the provisions of P.L. 1993, c.235 (enacted August 9, 1993), which provide new minimum capital and surplus requirements and authorize the Commissioner to increase these requirements for individual insurers based upon the insurer's business risks.

11:2-39.2 Definitions

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

"Adjusted RBC Report" means an RBC Report which has been adjusted by the Commissioner in accordance with N.J.A.C. 11:2-39.3(d).

"Corrective *[Order]* ***order***" means an order issued by the Commissioner in accordance with N.J.A.C. 11:2-39.5(b).

"NAIC" means the National Association of Insurance Commissioners.

"NAIC RBC Instructions" means the form of the Life Risk-Based Capital Report and instructions for completing such form adopted by the NAIC, as such form and instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

"NAIC RBC Report" means the Life Risk-Based Capital Report prepared pursuant to the NAIC RBC Instructions.

"Negative trend" means a negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the NAIC RBC Instructions.

"RBC" means Risk-Based Capital.

"RBC Instructions" means the NAIC RBC Instructions as supplemented by the Commissioner.

"RBC Level" means an insurer's Company Action Level RBC, Regulatory Action Level RBC, Authorized Control Level RBC, or Mandatory Control Level RBC where:

1. "Company Action Level RBC" means, with respect to any insurer, the product of 2.0 and its Authorized Control Level RBC;
2. "Regulatory Action Level RBC" means, with respect to any insurer, the product of 1.5 and its Authorized Control Level RBC;
3. "Authorized Control Level RBC" means, with respect to any insurer, the number determined under the risk-based capital formula in accordance with the RBC Instructions; and
4. "Mandatory Control Level RBC" means, with respect to any insurer, the product of .70 and its Authorized Control Level RBC.

"RBC Plan" means a comprehensive financial plan containing the elements specified at N.J.A.C. 11:2-39.4(b). If the Commissioner rejects the RBC Plan, and it is revised by the insurer, with or without the Commissioner's recommendation, the plan shall be called the "Revised RBC Plan."

"RBC Report" means the NAIC RBC Report as supplemented pursuant to the RBC Instructions.

"Required capital" is zero for any mutual insurer, and for any stock insurer means:

1. $1,000,000 for either or both kinds of business specified in N.J.S.A. 17B:17-3 and 5;
2. $700,000 for the kind of business specified in N.J.S.A. 17B:17-4; and
3. $1,530,000 for all three kinds of business specified in N.J.S.A. 17B:17-3, 4 and 5.

"Required surplus" means, for any insurer, such amount of statutory surplus as would cause the insurer's total adjusted capital to equal its Mandatory Control Level RBC, but in no event less than:

1. For either or both kinds of business specified in N.J.S.A. 17B:17-3 and 5, $4,000,000;
2. For the kind of business specified in N.J.S.A. 17B:17-4, $2,800,000 for a stock insurer or $3,000,000 for a mutual insurer; and
3. For all three kinds of business specified in N.J.S.A. 17B:17-3, 4 and 5, $6,120,000 for a stock insurer or $6,300,000 for a mutual insurer.

"Total adjusted capital" means an insurer's statutory capital and surplus increased or decreased by such other items, if any, as the RBC Instructions may provide.

11:2-39.3 RBC reports

(a) Every domestic insurer authorized to write life insurance, health insurance or annuity business in this State shall, on or before each March 15 (the "filing date"), prepare and submit to the Commissioner an RBC Report as of the preceding December 31. The RBC Report shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, RBC Reports
20 West State Street
CN 325
Trenton, New Jersey 08625

(b) If at any time the Commissioner believes that the financial condition of an insurer authorized to write life insurance, health insurance or annuity business in this State may have materially changed, the Commissioner may request in writing an updated RBC Report from the insurer. In such event, the insurer shall, on or before the 45th day following such request (the "filing date"), prepare and submit to the Commissioner at the address in (a) above an RBC Report as of the last day of the calendar month coincident with or last preceding the date of the request.

(c) Every domestic insurer shall also file its NAIC RBC Report with the NAIC in accordance with the NAIC RBC Instructions. In addition, if the insurer has been notified in writing by the insurance department of any state in which the insurer is authorized to do business, the insurer shall file its NAIC RBC Report with such state by the filing date or, if later, within 15 days from receipt of notice to file.

(d) If an insurer files an RBC Report which in the judgment of the Commissioner is inaccurate, then the Commissioner shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment.

(e) The calculation of an insurer's required surplus as set forth in an RBC Report filed and accepted by the Commissioner pursuant to (a) or (b) above, or as adjusted by the Commissioner pursuant to (d) above, shall be deemed to be a redetermination of the insurer's minimum statutory capital and surplus requirement pursuant to P.L. 1993, c.235, §4.

1. If an insurer disagrees with the minimum capital and surplus as determined above, it may request a hearing as provided at N.J.A.C. 11:2-39.9.

2. An insurer requesting a hearing shall do so upon filing an RBC Report, or within 20 days of receipt of notice from the Commissioner of an adjustment.

3. Failure to request a hearing shall be deemed to be a waiver of the right to a hearing on the redetermined minimum capital and surplus requirement for the insurer.

11:2-39.4 Company action level event

(a) "Company action level event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that:

i. The insurer's *[Total Adjusted Capital]* ***total adjusted capital*** is greater than or equal to its Regulatory Action Level RBC but less than its Company Action Level RBC; or

ii. The insurer has total adjusted capital which is greater than or equal to its Company Action Level RBC but less than the product of its Authorized Control Level RBC and 2.5 and has a negative trend;

2. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1i or ii above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9; or

3. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1i or ii above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a company action level event, a domestic insurer shall within 45 days prepare and submit to the Commissioner an RBC Plan which shall:

1. Identify the conditions in the insurer which contribute to the company action level event;

2. Set forth corrective actions which the insurer intends to take that are reasonably expected to result in the elimination of the company action level event;

3. Provide projections of the insurer's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and/or surplus. (The projections of both new and renewal business shall include separate projections for each major line of business and separately identify each significant income, expense and benefit component);

4. Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

5. Identify the quality of, and problems associated with, the insurer's business including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance in each case, if any.

(c) Within 60 days after the submission by a domestic insurer of an RBC Plan or a Revised RBC Plan to the Commissioner, the Commissioner shall notify the insurer whether such Plan shall be implemented or is, in the judgment of the Commissioner, unsatisfactory. If the Commissioner determines that the Plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the Plan satisfactory, in the judgment of the Commissioner. The Commissioner may, at his or her discretion, subject to the insurer's right to a hearing under N.J.A.C. 11:2-39.9, specify in the notification that the notification constitutes a regulatory action level event. Upon notification from the Commissioner, the insurer shall prepare a Revised RBC Plan, which may incorporate by reference any revisions proposed by the Commissioner, and shall submit the Revised RBC Plan to the Commissioner:

1. Within 45 days after the notification from the Commissioner; or

2. If the insurer challenges the notification from the Commissioner under N.J.A.C. 11:2-39.9, within 45 days after a notification to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(d) Every domestic insurer that flies an RBC Plan or Revised RBC Plan with the Commissioner shall file a copy of the RBC Plan or Revised RBC Plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

1. Such state has a confidentiality provision substantially similar to N.J.A.C. 11:2-39.10(a); and

2. The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC Plan or Revised RBC Plan in that state no later than the later of:

i. Fifteen days after the receipt of notice to file a copy of its RBC Plan or Revised RBC Plan with the state; or

ii. The date on which the RBC Plan or Revised RBC Plan is filed under (b) or (c) above.

11:2-39.5 Regulatory action level event

(a) "Regulatory action level event" means, with respect to any insurer, any of the following events:

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus is at least 110 percent but less than 125 percent of the sum of its required capital and required surplus.

2. The filing of an RBC Report by an insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Authorized Control Level RBC but less than its Regulatory Action Level RBC;

3. The notification by the Commissioner to an insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to file an RBC Report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured the failure within 10 days after the filing date;

6. The failure of the insurer to comply with the filing deadlines set forth at N.J.A.C. 11:2-39.4(b) and (c);

7. Notification by the Commissioner to the insurer that:

i. An RBC Plan or Revised RBC Plan submitted by the insurer is, in the judgment of the Commissioner, unsatisfactory; and

ii. Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under N.J.A.C. 11:2-39.9;

8. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)7 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected such challenge;

9. Notification by the Commissioner to the insurer that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event in accordance with its RBC Plan or Revised RBC Plan and the Commissioner has so stated in the notification, provided the insurer has not challenged the determination under N.J.A.C. 11:2-39.9; or

10. If the insurer, under N.J.A.C. 11:2-39.9, challenges a determination by the Commissioner pursuant to (a)9 above, the notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the challenge (unless the failure of the insurer to adhere to its RBC Plan or Revised RBC Plan has no substantial adverse effect on the ability of the insurer to eliminate the regulatory action level event with respect to the insurer).

(b) In the event of a regulatory action level event, the Commissioner shall for a domestic insurer, and may for a foreign insurer pursuant to N.J.A.C. 11:2-39.12:

1. Require the insurer to prepare and, within 45 days, submit an RBC Plan or, if applicable, a Revised RBC Plan;

2. Perform such examination or analysis as the Commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC Plan or Revised RBC Plan; and

3. Subsequent to the examination or analysis, issue a *[Corrective Order]* ***corrective order*** specifying such corrective actions as the Commissioner shall determine are required.

(c) In determining corrective actions, the Commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the Commissioner's examination or analysis of the assets, liabilities and operations of the insurer including, but not limited to, the results of any sensitivity tests undertaken pursuant to the RBC Instructions.

(d) The Commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the Commissioner to review the insurer's RBC Plan or Revised RBC Plan, examine and analyze the assets, liabilities and operations of the insurer and formulate the *[Corrective Order]* ***corrective order*** with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other affiliated or controlling party as directed by the Commissioner.

11:2-39.6 Authorized control level event

(a) "Authorized control level event" means any of the following events:

1. The filing of an RBC Report by an insurer which indicates that the sum of its capital and statutory surplus equals or exceeds by less than 10 percent the sum of its required capital and required surplus.

2. The filing of an RBC Report by an insurer which indicates that the insurer's total adjusted capital is greater than or equal to its Mandatory Control Level RBC but less than its Authorized Control Level RBC;

3. The notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates an event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9;

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates an event in (a)1 or 2 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge;

5. The failure of the insurer to comply with the filing deadline set forth at N.J.A.C. 11:2-39.5(b)1, unless the insurer has provided an explanation for such failure which is satisfactory to the Commissioner and has cured such failure within 10 days after the deadline.

6. The failure of the insurer to respond, in a manner satisfactory to the Commissioner, to a corrective order, provided the insurer has not challenged the corrective order under N.J.A.C. 11:2-39.9; or

7. If the insurer has challenged a corrective order under N.J.A.C. 11:2-39.9 and the Commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the Commissioner, to the corrective order subsequent to rejection or modification by the Commissioner.

(b) In the event of an authorized control level event with respect to an insurer, the Commissioner shall:

1. Take such actions as are required under N.J.A.C. 11:2-39.5 regarding an insurer with respect to which a regulatory action level event has occurred; or

2. If the Commissioner deems it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control pursuant to N.J.S.A. 17B:32-31 et seq. In the event the Commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act.

11:2-39.7 Mandatory control level event

(a) "Mandatory control level event" means any of the following events:

1. The filing of an RBC Report which indicates that the sum of the insurer's capital and statutory surplus is less than the sum of its required capital and required surplus;

2. The filing of an RBC Report which indicates that the insurer's total adjusted capital is less than its Mandatory Control Level RBC;

3. Notification by the Commissioner to the insurer of an Adjusted RBC Report that indicates the event in (a)1 or 2 above, provided the insurer does not challenge the Adjusted RBC Report under N.J.A.C. 11:2-39.9; or

4. If the insurer, under N.J.A.C. 11:2-39.9, challenges an Adjusted RBC Report that indicates the event in (a)1 or 2 above, notification by the Commissioner to the insurer that the Commissioner has, after a hearing, rejected the insurer's challenge.

(b) In the event of a mandatory control level event as set forth in (a)2, 3 or 4 above, the Commissioner shall take actions necessary to cause a domestic insurer to be placed under regulatory control pursuant to N.J.S.A. 17B:32-31 et seq. In that event, the mandatory control level event shall be deemed sufficient grounds for the Commissioner to take action under the said Act, and the Commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in the said Act. In the event the Commissioner takes actions pursuant to an Adjusted RBC Report, the insurer shall be entitled to such protections as are afforded to insurers under provisions of the said Act. Notwithstanding any of the foregoing, the Commissioner may forego action for up to 90 days after the mandatory control level event if he or she finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period. In the event of a mandatory control level event as set forth in (a)1 above, the Commissioner may take such action as provided in this subsection.

11:2-39.8 Filings of RBC Plans

A filing of an RBC Plan pursuant to N.J.A.C. 11:2-39.4(b), 5(b) or 15(a)2 shall be accompanied by a nonrefundable filing fee of $500.00 and shall be sent or delivered to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

11:2-39.9 Hearings

(a) An insurer shall have the right to a departmental hearing, on a record, at which the insurer may challenge any determination or action by the Commissioner.

(b) The insurer shall notify the Commissioner of its request for a hearing within five days upon:

1. Notification to the insurer by the Commissioner of an Adjusted RBC Report; or

2. Notification to the insurer by the Commissioner that:

i. The insurer's RBC Plan or Revised RBC Plan is unsatisfactory; and

ii. Such notification constitutes a *[Regulatory Action Level Event]* ***regulatory action level event*** with respect to such insurer; or

3. Notification to any insurer by the Commissioner that the insurer has failed to adhere to its RBC Plan or Revised RBC Plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the *[Company Action Level Event or Regulatory Action Level Event]* ***company action level event or regulatory action level event*** with respect to the insurer in accordance with its RBC Plan or Revised RBC Plan; or

4. Notification to the insurer by the Commissioner of a *[Corrective Order]* ***corrective order*** with respect to the insurer; or

5. Increased requirements pursuant to P.L. 1993, c.235, §4.

(c) Upon receipt of the insurer's request for a hearing, the Commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 20 days after the date of the Commissioner's notice to the insurer granting the hearing.

(d) All matters pertaining to a hearing or to an increase of capital or surplus pursuant to these rules shall be confidential and not subject to subpoena or public inspection, except to the extent that the Commissioner finds release of information necessary to protect the public.

(e) Failure to request a hearing upon filing of an RBC Report or failure to request a hearing within 20 days of notice of an Adjusted RBC Report shall be deemed a waiver of an insurer's right to a hearing pursuant to P.L. 1993, c.235, §4.

11:2-39.10 Confidentiality and prohibition on announcements

(a) All RBC Reports (to the extent the information therein is not required to be set forth in a publicly available annual statement schedule) and RBC Plans (including the results or reports of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the Commissioner pursuant to examination or analysis) with respect to any domestic insurer or foreign insurer which are filed with the Commissioner constitute information that might be damaging to the insurer if made available to its competitors, and therefore shall be kept confidential by the Commissioner. This information shall not be made public and/or be subject to subpoena, other than by the Commissioner and then only for the purpose of enforcement actions taken by the Commissioner pursuant to this subchapter or any other provision of the insurance laws of this State.

(b) The comparison of an insurer's total adjusted capital to any of its RBC Levels is a regulatory tool which may indicate the need for possible corrective action with respect to the insurer, and is not intended as a means to rank insurers generally. Therefore, except as otherwise required under the provisions of this subchapter, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC Levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business would be misleading and is therefore prohibited; provided, however, that if any materially false statement with respect to the comparison regarding an insurer's total adjusted capital to its RBC Levels (or any of them) or an inappropriate comparison of any other amount to the insurer's RBC Levels is published in any written publication and the insurer is able to demonstrate to the Commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

11:2-39.11 Supplemental provisions

The provisions of this subchapter are supplemental to any other provisions of the laws of this State, and shall not preclude a limit any other powers or duties of the Commissioner under such laws including, but not limited to, N.J.S.A. 17B:32-31 et seq. and N.J.A.C. 11:2-27.

11:2-39.12 Foreign insurers

(a) Any foreign insurer shall, upon the written request of the Commissioner, submit to the Commissioner an RBC Report as of the end of the calendar year just ended the later of the filing date or within 15 days after the request is received by the foreign insurer.

(b) Any foreign insurer admitted to transact business in this State shall promptly submit to the Commissioner a copy of any RBC Plan or Revised RBC Plan that is filed with the insurance commissioner of any other state.

(c) In the event of a company action level event or regulatory action level event with respect to any foreign insurer, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file an RBC Plan in a manner substantially similar to that specified under N.J.A.C. 11:2-39.4, the Commissioner may require the foreign insurer to file an RBC Plan with the Commissioner. In such event, the failure of the foreign insurer to file an RBC Plan with the Commissioner shall be grounds to order the insurer to cease and desist from writing new business in this State.

(d) In the event of an authorized control level event or a mandatory control level event with respect to any foreign insurer, if no domicilary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the Commissioner may make application to the Superior Court pursuant to N.J.S.A. 17B:32-31 et seq. with respect to the liquidation of property of foreign insurers found in this State, and the occurrence of the *[Authorized Control Level Event or Mandatory Control Level Event]* ***authorized control level event or mandatory control level event*** shall be considered adequate grounds for the application.

11:2-39.13 Severability clause

If any provision of this subchapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this subchapter which can be given effect without the invalid provision or application, and to that end the provisions of this subchapter are severable.

11:2-39.14 Notices

All notices by the Commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail to the insurer's mailing address as provided pursuant to N.J.A.C. 11:1-25 or, in the case of any other transmission, shall be effective upon the insurer's receipt of such notice.

11:2-39.15 Phase-in provision

(a) An insurer subject to this subchapter may request a temporary waiver of the minimum capital and surplus requirements set forth in P.L. 1993, c.235 as follows:

1. The insurer must make application in writing to the Commissioner by October 15, 1993. The waiver request shall be forwarded to:

New Jersey Department of Insurance
Financial Examinations, Capital and Surplus Waivers
20 West State Street
CN 325
Trenton, New Jersey 08625

2. Filing the waiver request shall constitute a regulatory action level event. The insurer shall prepare and file an RBC Plan with the Commissioner at the same address as set forth above, but the time for filing the RBC Plan shall be extended to 120 days. After such review, examination and analysis as is deemed necessary, the

Commissioner shall issue a corrective order which may include an appropriate limited waiver of the minimum capital and surplus requirements. In no event shall the corrective order temporarily waive the applicable capital and surplus requirements for a period of more than five years.

3. If the insurer is responding to the corrective order in a manner satisfactory to the Commissioner, then the filing of an RBC Report shall not constitute an authorized control level event or a mandatory control level event.

4. Solely for the purpose of this subsection, an insurer's RBC Plan may be limited to a certification that its capital and surplus meet the minimum requirements set forth in P.L. 1993, c.235 as of December 31, 1993. Such certification shall be signed by the insurer's Chief Executive Officer and shall have the effect of terminating the regulatory action level event. The Commissioner may request that the insurer submit additional documentation to support the certification, if necessary.

(b) For RBC Reports required to be filed with respect to 1993, the following requirements shall apply in lieu of the provisions of N.J.A.C. 11:2-39.5, 39.6 and 39.7:

1. In the event of a regulatory action level event under N.J.A.C. 11:2-39.5(a)1, 2 or 3, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.4.

2. In the event of a regulatory action level event under N.J.A.C. 11:2-39.5(a)4, 5, 6, 7 or 9 or an authorized control level event, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.5 with respect to the insurer.

3. In the event of a mandatory control level event with respect to an insurer, the Commissioner shall take the actions required under N.J.A.C. 11:2-39.6 with respect to the insurer.

(c) Until August 16, 1996, all insurers shall be deemed to have applied for, and been granted, a waiver from the requirement of P.L. 1993, c.235 §2 to maintain their minimum capital and surplus in cash and short term assets. This waiver shall not be construed to prevent the Commissioner from taking any other action authorized by law with regard to an insurer's financial condition including, but not limited to, action pursuant to N.J.S.A. 17B:32-31 et seq.; P.L. 1993, c.245; and N.J.A.C. 11:2-27.

(a)

DIVISION OF ACTUARIAL SERVICES

Life, Health and Annuity Reinsurance Agreements Adopted Concurrent New Rules: N.J.A.C. 11:2-40

Proposed: September 7, 1993 at 25 N.J.R. 4314(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.562, **with substantive and technical changes** not requiring additional public comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1-8.1, 17:1C-6, 17:23-1 et seq., 17:44A-24, 17:45-1 et seq., 17B:18-62 et seq., 17B:21-1 et seq., and P.L. 1993, c.243.

Effective Date: October 15, 1993, Readoption of emergency new rules;
November 15, 1993, Changes upon adoption.
Expiration Date: November 30, 1995.

These new rules were adopted on an emergency basis and concurrently proposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c). The present adoption of the concurrent proposed rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for changes upon adoption, which are effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

The Department received one comment on the proposed rules from Prudential Insurance Company.

COMMENT: The commenter stated that proposed N.J.A.C. 11:2-40.3 and 40.6 requiring Department approval of all reinsurance agreements and amendments to agreements, and the submission of certain financial information with the agreements, would impede the timely signing of agreements, add to administrative expense, and have a chilling effect on reinsurance agreements that should be supported as a matter of public policy. According to the commenter, certain reinsurance agreements are routinely entered into and are relatively simple arrangements, for which credits for reserves held by an appropriately licensed reinsurer are taken. A requirement that such agreements, together with actuarial memoranda, be filed with Department could make the cost of the agreements prohibitive, although the impact on surplus is negligible. The commenter requested that these proposed rule provisions be removed, or, alternatively, that the provisions be restricted to agreements having a material impact on surplus.

RESPONSE: It is the Department's position that filing reinsurance agreements with the Commissioner would not significantly burden those insurers entering into such agreements. It has all along been the Department's intent to require the approval of only those reinsurance agreements over which the Commissioner has been granted statutory prior approval authority pursuant to N.J.S.A. 17B:18-64. This statutory provision states that all reinsurance agreements entered into by domestic insurers shall be submitted to the Commissioner for approval, except those agreements reinsuring single risks or policies, in whole or in part, or risks covered by any group policy or contract, in whole or in part. Additionally, this provision requires the Commissioner's approval for all reinsurance agreements where a domestic mutual insurer cedes all or any substantial part of its risks to a stock insurer. Accordingly, the Department is revising N.J.A.C. 11:2-40.3 to more accurately reflect that intent. Nevertheless, the Department believes that the filing of all reinsurance agreements as well as the submission of the actuarial information pursuant to N.J.A.C. 11:2-40.6, are necessary in the Department's determination of compliance with the proposed rules.

Summary of Changes Upon Adoption:

1. Proposed N.J.A.C. 11:2-40.1(b3) has been deleted as being duplicative of N.J.A.C. 11:2-40.1(b)1 and 2.

2. Proposed N.J.A.C. 11:2-40.1(c) has been revised for purposes of clarification. As proposed, this provision stated that certain provisions of rules are not applicable to nonproportional reinsurance. The term "nonproportional reinsurance" was not defined in the proposal. Accordingly, the words "catastrophe, stop-loss or other" have been added since they are types of nonproportional reinsurance, and have been defined in the proposal.

3. N.J.A.C. 11:2-40.3(a) has been amended for clarification purposes by adding language previously appearing at N.J.A.C. 11:2-40.6(a), which sets forth the documentation required to be submitted to the Department with the reinsurance agreements to be filed. This change was made so that all documents required to be submitted for filing appear in one section of this subchapter.

4. At N.J.A.C. 11:2-40.3(a)1, (b)1 and (b)3, the words "for which the Commissioner has been granted statutory prior approval authority" have been added as a result of the comment received by the Department. This language serves to clarify the Department's intent that the Commissioner approve only those reinsurance agreements over which he or she has been granted such statutory authority, not all reinsurance agreements.

5. On Exhibit 2 in the Appendix, for clarification, a line has been inserted in the formula appearing in the Exhibit which did not appear on proposal.

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

SUBCHAPTER 40. LIFE, HEALTH AND ANNUITY REINSURANCE AGREEMENTS

11:2-40.1 Purpose and scope

(a) The purpose of this subchapter is to provide standards for reinsurance agreements pursuant to which a ceding insurer may reduce a liability or establish an asset on any financial statements filed with the Department.

(b) This subchapter shall apply to the following:

1. All domestic insurers authorized to transact life insurance, accident and health insurance or annuity business in this State;

2. All foreign and alien insurers authorized to transact life insurance, accident and health insurance or annuity business in this

State which otherwise are not subject to rules in their state of domicile that are substantially similar to those contained herein;

[3. All property and casualty insurers authorized to transact accident and health insurance;]

*[4.]***3.*** All reinsurers authorized to effect life, accident and health or annuity reinsurance agreements in this State; and

*[5.]***4.*** All reinsurance agreements entered into by an entity subject to this subchapter, except as N.J.A.C. 11:2-40.5 may apply.

(c) This subchapter shall not apply with respect to assumption reinsurance agreements. N.J.A.C. 11:2-40.4(a)1, 4, 6 and 7 shall not apply to ***catastrophe, stop-loss or other*** nonproportional reinsurance. N.J.A.C. 11:2-40.4(a)4, 6 and 7 shall not apply to term reinsurance.

11:2-40.2 Definitions

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

"Actuary" means a Member of the American Academy of Actuaries or a Fellow of the Society of Actuaries or a Fellow of the Casualty Actuarial Society who is qualified by training and experience, pursuant to the standards promulgated by the Actuarial Standards Board, to provide the opinions required in this subchapter.

"Assumption reinsurance" means reinsurance whereby the reinsurer assumes from the ceding insurer all risks, obligations, duties and rights arising under a policy; following assumption, a policy is treated by all persons as if the reinsurer were the insurer which had issued the policy.

"Authorized" means that an insurer has a certificate of authority issued by the Commissioner to act as an insurer in this State pursuant to Title 17 or 17B of the New Jersey Statutes.

"Catastrophe reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies as a result of a single event or occurrence, such as an accident or a storm, will exceed a defined threshold number or amount.

"Ceding insurer" means an insurer which procures indemnification for itself from another insurer with respect to all or part of an insurance risk associated with one or more policies issued by the former insurer, should losses be sustained.

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

"Department" means the New Jersey Department of Insurance.

"Domestic" means an entity formed under the laws of this State.

"Insurer" means any person or entity transacting the business of life, accident or health insurance, or annuities.

"LTC" means long-term care insurance.

"Policy" means any life insurance, health insurance or annuity policy or contract, as defined pursuant to N.J.S.A. 17B:17-3, 4 and 5, which is not reinsurance.

"Reinsurance" means a contractual arrangement whereby an insurer, for some consideration, agrees to indemnify a ceding insurer for all or part of a loss which the ceding insurer may incur under one or more policies that the ceding insurer has or will issue. This term is intended to include facultative reinsurance, automatic reinsurance agreements, reinsurance agreements of pools and associations, and such other similar reinsurance arrangements by whatever name or device.

"Reinsurance credit" means the amount of a liability reduction or the asset established as permitted by this subchapter.

"Reinsurer" means an insurer which agrees to provide reinsurance.

"Renewable term reinsurance" means term reinsurance which is renewable, automatically or at the option of the ceding insurer, for successive terms at rates not exceeding those guaranteed in the reinsurance agreement.

"Significant risk" means an element of risk associated with a policy such that the actual experience of an insurer related to such element will have a direct and material effect on the profit or loss realized by the insurer as a consequence of having issued or assumed such policy.

"Stop-loss reinsurance" means reinsurance of the risk that the aggregate number or dollar amount of claims incurred under a set of policies during a specified period will exceed a defined threshold number or amount.

"Term reinsurance" means reinsurance of the risk that a mortality or morbidity claim on an insured life will be incurred during a specified term, such as one year.

11:2-40.3 Reinsurance agreements

(a) No ceding insurer subject to this subchapter shall enter into any new reinsurance agreement, nor amend any existing reinsurance agreement so as to increase its reinsurance credit, which shall reduce any liability or establish any asset in any financial statement filed with the Department except pursuant to the following requirements:

1. The reinsurance agreement or amendment shall be filed with the Commissioner no later than 30 days after its execution. In addition, no domestic insurer shall enter into any reinsurance agreement ***for which the Commissioner has been granted statutory prior approval authority*** involving a substantial transfer of risk without the prior approval of the Commissioner. For purposes of this subsection, a transfer of risk associated with a reinsurance agreement is considered to be substantial if a material number or percentage of policies are affected by the agreement, or if there is a material change in the reserve liabilities on the policies affected by the agreement. Such agreements shall be submitted to:

Vaulation and Statement Bureau
Life and Health Actuarial Services
New Jersey Department of Insurance
CN 325
Trenton, NJ 08625-0325

2. This filing shall include a written opinion of an actuary representing the reinsurer which describes the ceding insurer's significant risks under the policies reinsured and specifies the extent (if any) to which these significant risks are transferred to the reinsurer.

3. Each reinsurance agreement filed with the Department shall be accompanied by documentation detailing the financial impact of the agreement. This documentation shall include information as to reserves transferred under the agreement and details as to payment and expense charges to and from each party to the agreement.

(b) No reinsurance agreement or amendment to any agreement may be used to reduce any liability or to establish any asset in any financial statement filed with the Department unless the agreement, amendment or a binding letter of intent has been duly executed by both parties no later than the last day of the period covered by the financial statement, filed with the Commissioner pursuant to (a) above and meets the following standards:

1. In the case of a letter of intent, the letter of intent shall stipulate that the reinsurance agreement is subject to approval by the Commissioner ***where the Commissioner has been granted statutory prior approval authority***, and that no reserve credits shall be taken by the insurer until the Commissioner has approved the agreement.

2. In the case of a letter of intent, a reinsurance agreement or an amendment to a reinsurance agreement must be executed within a reasonable period of time, not exceeding 90 days from the execution date of the letter of intent, and before the filing of the first financial statement in which a credit is to be taken, in order for credit to be granted for the reinsurance ceded.

3. The reinsurance agreement or amendment shall stipulate that coverage thereunder shall terminate if it is not approved by the Commissioner ***where the Commissioner has been granted statutory prior approval authority*** and that, in any financial statement filed before the Commissioner has approved it, the ceding insurer shall take no reinsurance credit therefor, other than for any net cash refund available in the event that the agreement is not approved.

4. The reinsurance agreement shall stipulate that the written agreement, including any written amendments thereto, as filed with the Commissioner constitutes the entire agreement between the parties with respect to the risks being reinsured thereunder. The reinsurance agreement shall further stipulate that to the extent the original agreement required prior approval by the Commissioner, any change or modification of its terms shall be null and void unless

made by written amendment signed by both parties and filed with the Commissioner for approval along with any necessary revisions to the actuarial opinion required by (a)2 above. There shall be no additional terms or conditions, either written or oral, and the parties to the reinsurance agreement shall not enter into any understandings or supplemental agreements with respect to the reinsurance, other than those set forth in the written agreement filed with the Commissioner.

5. The reinsurer shall not require, and the ceding insurer shall not make, any representations or warranties about the future experience under the policies being reinsured, nor any other representations or warranties which are not reasonably related to the policies being reinsured.

11:2-40.4 Agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Except as N.J.A.C. 11:2-40.5 applies, no insurer shall reduce any liability or establish any asset in any financial statement filed with the Department for any reinsurance ceded if by the terms of the reinsurance agreement, any of the following conditions exist, in substance or effect:

1. Renewal expense allowances provided or to be provided to the ceding insurer by the reinsurer in any accounting period are not sufficient to cover anticipated allocable renewal expenses of the ceding insurer on the portion of the business reinsured unless an adequate liability is established by the ceding insurer for the present value of the shortfall by taking into consideration assumptions equal to the applicable statutory reserve basis on the business reinsured. Those expenses include commissions, premium taxes and direct expenses including, but not limited to, billing, valuation, claims and maintenance expected by the ceding insurer at the time the business is reinsured;

2. The ceding insurer can be deprived of surplus or assets at the reinsurer's option or automatically upon the occurrence of some event, such as the insolvency of the ceding insurer, except that termination of the reinsurance agreement by the reinsurer for nonpayment of reinsurance premiums or other amounts due, such as modified coinsurance reserve adjustments, interest and adjustments on funds withheld, and tax reimbursements, shall not be considered to be such a deprivation of surplus or assets;

3. The ceding insurer is required to reimburse the reinsurer for negative experience under the reinsurance agreement, except that neither offsetting experience refunds against current and prior years' losses under the agreement nor payment by the ceding insurer of an amount equal to the current and prior years' losses under the agreement upon voluntary termination of in force reinsurance by the ceding insurer shall be considered such a reimbursement to the reinsurer for negatives experience. Voluntary termination does not include situations where termination occurs because of unreasonable provisions which allow the reinsurer to reduce its risk under the agreement. An example of such a provision is the right of the reinsurer to increase reinsurance premiums or risk and expense charges to excessive levels forcing the ceding company to prematurely terminate the reinsurance treaty;

4. The ceding insurer is required, at specific points in time scheduled in the agreement, to terminate or automatically recapture all or part of the reinsurance ceded;

5. The reinsurance agreement involves the possible payment by the ceding insurer to the reinsurer of amounts other than from income realized from the reinsured policies. For example, it is improper for a ceding company to pay reinsurance premiums, or other fees or charges to a reinsurer which are greater than the direct premiums collected by the ceding company;

6. The treaty does not transfer all of the significant risk inherent in the business being reinsured. Exhibit 1 entitled "Significant Risks" appearing in the Appendix to this subchapter identifies the risks considered to be significant for the various products or types of business set forth in the table. For products not specifically included, the risks determined to be significant shall be consistent with this table;

7. The credit quality, reinvestment, or disintermediation risk is significant for the business reinsured and the ceding company does not (other than for the classes of business excepted in (a)8 below) either transfer the underlying assets to the reinsurer, maintain such assets in a separate trust or escrow account, or otherwise establish a mechanism by contractual arrangement satisfactory to the Commissioner whereby the underlying assets are legally segregated;

8. Notwithstanding the requirements of (a)7 above, the assets supporting the reserves for the following classes of business and any classes of business which do not have a significant credit quality, reinvestment, or disintermediation risk may be held by the ceding company without segregation of such assets: Health Insurance—LTC/LTD; Traditional Non-Par Permanent; Traditional Par Permanent; Adjustable Premium Permanent; Indeterminate Premium Permanent; and Universal Life Fixed Premium (no dump-in premiums allowed). The formula for determining the reserve interest rate adjustment should reflect the ceding company's investment earnings and incorporate all realized and unrealized gains and losses reflected in the financial statement. The formula set forth as Exhibit 2 in the Appendix to this subchapter is an example of an acceptable formula;

9. Settlements are made less frequently than quarterly or payments due from the reinsurer are not made in cash within 90 days of the settlement date;

10. The ceding insurer is required to make representations or warranties which are not reasonably related to the business being reinsured;

11. The ceding insurer is required to make representations or warranties about future performance of the business being reinsured;

12. The reinsurance agreement is entered into for the principal purpose of producing significant surplus aid for the ceding insurer, typically on a temporary basis, while not transferring all of the significant risks inherent in the business reinsured and, in substance or effect, the expected potential liability to the ceding insurer remains basically unchanged.

(b) Notwithstanding (a) above, in financial statements filed with the Department a ceding insurer subject to this subchapter may, with the prior approval of the Commissioner, take such reinsurance credit as the Commissioner may deem consistent with the fair presentation of the insurer's financial condition under statutory accounting principles (as permitted or prescribed by Title 17B of the New Jersey revised statutes and rules and regulations promulgated thereunder), including actuarial interpretations and standards adopted by the Department.

11:2-40.5 Exceptions to agreements or conditions precluding reduction of liability or inclusion as an asset

(a) Agreements entered into on or after August 16, 1993 which involve the reinsurance of business issued prior to the effective date of the agreements, along with any subsequent amendments thereto, shall be filed by the ceding company with the Commissioner within 30 days from their date of execution.

(b) Any increase in surplus net of Federal income tax resulting from arrangements described in (a) above shall be identified separately on the insurer's financial statement as a surplus item (aggregate write-ins for gains and losses in surplus in the Capital and Surplus Account, page 4 of the Annual Statement) and recognition of the surplus increase as income shall be reflected on a net of tax basis in the "Reinsurance Ceded" line, page 4 of the Annual Statement as earnings emerge from the business reinsured.

(c) Insurers subject to this subchapter shall reduce to zero by December 31, 1995 any reserve credits or assets established with respect to reinsurance agreements entered into prior to August 16, 1993 which, under the provisions of this subchapter would not be entitled to recognition of the reserve credits or assets; provided, however, that the reinsurance agreements shall have been in compliance with laws or regulations in existence immediately preceding August 16, 1993.

11:2-40.6 Additional standards

(a) *[Each reinsurance agreement filed with the Department shall be accompanied by documentation detailing the financial impact of the agreement. This documentation shall include information as to reserves transferred under the agreement and details as to payment

and expense charges to and from each party to the agreement.]* The ceding insurer's actuary signing the financial statement actuarial opinion with respect to the valuation of reserves shall consider this subchapter and any applicable actuarial standards of practice when determining the proper credit in financial statements filed with the Department. The actuary shall maintain adequate documentation and be prepared upon request by the Department to describe the actuarial work performed for inclusion in the financial statements and to demonstrate that such work conforms to this subchapter.

(b) Compliance with N.J.A.C. 11:2-40.4 shall not abrogate the requirement that reserve credits shall be based upon actual liability assumed by a reinsurer to reimburse a ceding insurer for benefits that the ceding insurer is obligated to pay under its direct policies and that gave rise to a required statutory reserve amount. An agreement meeting the technical requirements of N.J.A.C. 11:2-40.4, but failing to comply with the objective of this rule, shall not provide a basis for the taking of reserve credits by a ceding insurer.

(c) The ceding insurer shall maintain data used to determine reinsurance credits at its place of business for review by the Department upon request. Such data and documentation shall demonstrate compliance by the ceding insurer with this subchapter, and shall include, but not be limited to:

1. A comparison of the renewal expense allowances with the ceding insurer's anticipated expenses; and
2. A comparison of the guaranteed reserve adjustment interest rates to the maximum allowable statutory valuation rates in accordance with N.J.S.A. 17B:19-8.

11:2-40.7 Penalties

Failure to comply with the terms of this subchapter may result in the denial of any credit taken for the reinsurance agreement, as well as the assessment of any and all penalties available pursuant to law. These penalties may be assessed against any and all parties to a reinsurance agreement that fails to comply with the terms of this subchapter.

11:2-40.8 Severability

If any provision of this subchapter or the application thereof to any person or circumstance is held to be invalid for any reason, the remainder of the subchapter and the application of such provision to other persons or circumstances shall not be affected thereby.

APPENDIX

EXHIBIT 1

Significant Risks

Products/Types of Business	Risk Categories** a	b	c	d	e	f
Health Insurance—other than LTC/LTD*	+	O	+	O	O	O
Health Insurance—LTC/LTD*	+	O	+	+	+	O
Immediate Annuities	O	+	O	+	+	O
Single Premium Deferred Annuities	O	O	+	+	+	+
Flexible Premium Deferred Annuities	O	O	+	+	+	+
Guaranteed Interest Contracts	O	O	O	+	+	+
Other Annuity Deposit Business	O	O	+	+	+	+
Single Premium Whole Life	O	+	+	+	+	+
Traditional Non-Par Permanent	O	+	+	+	+	+
Traditional Non-Par Term	O	+	+	O	O	O
Traditional Par Permanent	O	+	+	+	+	+
Traditional Par Term	O	+	+	O	O	O
Adjustable Premium Permanent	O	+	+	+	+	+
Indeterminate Premium Permanent	O	+	+	+	+	+
Universal Life Flexible Premium	O	+	+	+	+	+
Universal Life Fixed Premium	O	+	+	+	+	+
Universal Life Fixed Premium dump-in premiums allowed	O	+	+	+	+	+

+ = Significant/O = Insignificant

*LTC = Long Term Care Insurance
LTD = Long Term Disability Insurance

**Risk categories

a. Morbidity

b. Mortality

c. Lapse. This is the risk that a policy will voluntarily terminate prior to the recoupment of a statutory surplus strain experienced at issue of the policy.

d. Credit Quality (C1). This is the risk that invested assets supporting the reinsured business will decrease in value. The main hazards are that assets will default or that there will be a decrease in earning power. It excludes market value declines due to changes in interest rate.

e. Reinvestment (C3). This is the risk that interest rates will fall and funds reinvested (coupon payments or monies received upon asset maturity or call) will therefore earn less than expected. If asset durations are less than liability durations, the mismatch will increase.

f. Disintermediation (C3). This is the risk that interest rates rise and policy loans and surrenders increase or maturing contracts do not renew at anticipated rates of renewal. If asset durations are greater than the liability durations, the mismatch will increase. Policyholders will move their funds into new products offering higher rates. The company may have to sell assets at a loss to provide for these withdrawals.

EXHIBIT 2

Formula for Determining Reserve Interest Rate Adjustment

[Rate = $\frac{2\ (I + CG)}{X + Y - I - CG}$]

Rate = $\frac{2\ (I + CG)}{X + Y - I - CG}$

Where: I is the net investment income

CG is capital gains less capital losses

X is the current year cash and invested assets plus investment income due and accrued less borrowed money

Y is the same as X but for the prior year

All data is as reported in the Annual Statement.

(a)

DIVISION OF PROPERTY AND CASUALTY

New Jersey Personal Automobile Insurance Plan

Adopted New Rule: N.J.A.C. 11:3-2.4

Adopted Amendments: N.J.A.C. 11:3-2.2, 2.5, 2.6, 2.11 and 2.12

Proposed: June 7, 1993 at 25 N.J.R. 2212(a).
Adopted: October 14, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 14, 1993 as R.1993 d.548, **with substantive changes** not requiring additional public comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1C-6(e), 17:1-8.1 and 17:29D-1.

Effective Date: November 15, 1993.
Expiration Date: January 4, 1996.

Summary of Public Comments and Agency Responses:

The Department of Insurance (Department) received six timely written comments from insurers as follows:

1. State Farm Indemnity Company;
2. Allstate Insurance Company;
3. Pennsylvania Millers Mutual Insurance Company;
4. Morgan, Melhuish, Monaghan, Arvidson, Abrutyn and Lisowski (on behalf of Rider Insurance Company);
5. Clarendon National Insurance Company; and
6. Universal Underwriters Group

COMMENT: One commenter objected to N.J.A.C. 11:3-2.4(c), which provides that insurers that currently insure, or have insured, since December 31, 1983, only certain types of automobiles (for example, motor homes, recreational vehicles, antique automobiles or motorcycles), shall participate in the Personal Automobile Insurance Plan (PAIP) only for the particular types of automobiles currently being insured. The commenter believes that this provision is contrary to the intent of N.J.S.A. 17:29D-1(c) which authorizes the use of Limited Assignment Distribution (LAD) carriers. The commenter stated that the intent of that statutory provision was to allow insurers that could not efficiently service all PAIP risks assigned to them to contract with another insurer to take its assignments. The commenter believes that insurers to which assignments are limited pursuant to N.J.A.C. 11:3-2.4(c) are insurers that cannot efficiently service all PAIP risks assigned to them. Accordingly, the commenter stated that it was intended that such insurers utilize the LAD option, rather than receive special treatment or restrictions on their assignments.

In addition, the commenter stated that restrictions on the type of automobiles that may be assigned to an insurer may result in an insurer being "underassigned." The commenter stated that because of regulations that apportion vehicles to drivers (that is, N.J.A.C. 11:3-8.4(a) and 11:3-35.4(d)), it is highly probable that the PAIP will not insure any significant number of recreational vehicles or antique automobiles. Accordingly, the commenter stated that "specialty" insurers will not receive their proprotionate share of assignments because not enough of these vehicles are insured through the PAIP. The commenter believes that this is inequitable. The commenter therefore suggested that N.J.A.C. 11:3-2.4(c) be deleted.

Conversely, one commenter "strongly favored" the provisions set forth in N.J.A.C. 11:3-2.4(c). The commenter stated that it is a specialty insurer for motorcycle and snowmobile insurance. The commenter stated that it does not presently insure, solicit, market or maintain any program of private passenger insurance. Without the "specialty writer" limited exemption, the commenter stated that it would be required to accept assignments of private passenger automobiles based on its motorcycle writings. Since it has only written specialty class vehicles, the commenter stated that it does not have systems or infrastructure to provide coverages for all types of automobiles which it would be required to cover under PAIP. The commenter stated that cost to "buy out" of its obligations through a LAD carrier arrangement would be unreasonably high since it does not insure any private passenger automobiles in the voluntary market.

The commenter further stated that because of its limited underwriting, the effect and benefit of any credits that are offered for the writing of "ineligible" risks provided pursuant to N.J.A.C. 11:3-2.11(a)4 is limited.

The commenter thus believes that adoption of the provision will provide "specialty" insurers an opportunity to write similar classes of assignments from PAIP, thereby promoting efficiency in the handling of assigned risks through PAIP.

RESPONSE: Upon review of the comments, the Department has determined that no change to the proposed provision is required. The Department does not believe that N.J.A.C. 11:3-2.4(c) is inconsistent with the provisions of N.J.S.A. 17:29D-1(c), which authorizes the use of LAD carriers by which member insurers of the PAIP may "buy-out" of their obligations to accept PAIP assignments.

The Department recognizes that the general intent of a LAD carrier system is to permit insurers that do not believe that they may efficiently service PAIP assignments to "buy-out" of their obligations to write such risks and transfer those obligations to the LAD carrier. However, the Department believes that the limitation on writings by "specialty writers" provided by the rules is reasonable and appropriate. A "specialty writer" does not participate in the voluntary private passenger automobile insurance market and writes no private passenger automobile risks. Accordingly, such insurers are not required to provide automobile insurance coverage to all eligible persons pursuant to N.J.A.C. 11:3-40. The Department does not believe it would be reasonable or equitable to require these insurers to write risks through the PAIP that they are not required to write in the voluntary market, or be required to incur the costs to "buy-out" of those obligations. As the Department noted in the proposal Summary (see 25 N.J.R. 2213), the Department believes that it is reasonable and appropriate to require insurers that insure or have insured only certain types of vehicles to participate in the PAIP only to the extent of those vehicles it insures. Since these insurers have written only certain types of vehicles in the voluntary market, these insurers may not have the systems and infrastructure in place to provide coverages for all types of automobiles which may be covered under the PAIP. Accordingly, the cost to provide such coverage or to "buy-out" of those obligations would be disproportionately high in the relation to the degree of their participation in the voluntary market.

Moreover, the Department does not believe that inequities result to the extent "specialty" vehicles are not insured by the PAIP. To the extent that "specialty" vehicles, such as motorcylces and motor homes, are not insured by the PAIP, they are insured in the voluntary market by specialty writers. Accordingly, while specialty writers may not be assigned risks through the PAIP, they are nevertheless servicing such business in the voluntary market. In either case, specialty writers are required to participate in the market for the types of vehicles it currently insures.

The Department thus believes that the provision is reasonable, appropriate, and equitable in that it requires insurers required to provide private passenger automobile insurance to eligible persons who participate in the voluntary private passenger automobile insurance market in the State to participate in the PAIP to the same extent.

COMMENT: Several commenters objected to N.J.A.C. 11:3-2.5(a)4, which provides that one of the members of the PAIP governing committee shall be a salaried employee of an approved LAD carrier for the PAIP. The commenters generally stated that since LAD carriers are insurers, they are currently represented by member insurers and therefore issues affecting LAD carriers may be addressed adequately by the current governing committee.

One commenter specifically stated several reasons in support of this position. First, because an approved LAD carrier is an insurer, it already has the right to nominate an insurer representative on the PAIP governing committee. Therefore, the proposed rule would give that member two votes. The first vote as an insurer and the second vote as an approved LAD carrier. The commenter stated that this is unfair, contrary to basic democratic principles, arbitrary and capricious, and may be in violation of the United States Constitution and New Jersey's State Constitution with respect to the principle of "one man-one vote."

Secondly, the commenter stated that the LAD carrier's relationship to the PAIP is entirely voluntary and that representation on the governing committee is intended for those entities who are compelled to participate in the PAIP (that is, automobile insurers, the general public for whom automobile insurance is compulsory, and for producers in that a producer cannot provide coverage for most ineligible persons without the PAIP). Because LAD carriers are purely volunteers, the commenter believes that these entities need not have a say in PAIP operations.

Thirdly, the commenter stated that because LAD carrier contracts are subject to governing committee approval, a LAD carrier representative would have a conflict of interest as to its own LAD carrier contracts, as well as when it rules on its competitors' LAD carrier contracts. The commenter further stated that potential conflict may also be created for the other members of the governing committee in that the disapproval by the governing committee of a LAD carrier's contract would also exclude that carrier from potential or actual representation on the governing committee. The commenter stated that the governing committee does not have the power to exclude any other type of carrier or representative from the governing committee and should not have this power with regard to any such group.

Fourthly, the commenter stated that since governing committee meetings are open to the public, anyone may attend and participate in discussions on any issues. Accordingly, the commenter believes that any person may participate in the meetings without necessarily being a member of the governing committee.

Finally, the commenter stated that the problems intended to be addressed through the rule may be addressed in a different manner. The commenter stated that one of the LAD carriers interested in becoming a member of the governing committee is also a large writer of automobile insurance in the State. The commenter stated that current PAIP rules allocate insurer seats by two for each of the trade associations and two for unaffiliated insurers. The commenter stated that this allocation is made by the rules without regard to market share, interest, or expertise of these trade associations or unaffiliated insurers. The commenter believes that it would be more appropriate for all eight insurer seats to be nominated by market share weighted voting of all insurers together. The commenter stated that under such a system, the LAD carrier would most likely be nominated to the governing committee as an insurer representative.

For the foregoing reasons, the commenter stated that proposed N.J.A.C. 11:3-2.5(a)4 should not be adopted.

RESPONSE: After review of the commenters' concerns, the Department has determined not to change this provision. Although LAD carriers are insurers (which are currently represented), they are subject to additional requirements pursuant to the Plan of Operation and LAD Program Manual when acting in the capacity of a LAD carrier. Accordingly, insurers which are also LAD carriers may have different interests and additional concerns than those of insurers that do not act as LAD carriers. The Department therefore believes that it is reasonable and appropriate to provide for a LAD carrier representative on the governing committee. The Department's response to the commenter's specific concerns is as follows.

First, the Department does not believe that permitting a LAD carrier to be a representative on the governing committee results in one insurer receiving "two votes." Under the existing regulatory scheme, an insurer representative on the governing committee may also be a LAD carrier. In that case, the representative could have "two interests" represented through his or her representation, but would still have only "one vote" on the governing committee. The only manner in which a single insurer representative would have two actual votes on the governing committee would be if the Commissioner appointed as the LAD carrier representative an employee of an insurer that is already represented on the governing committee. This would be highly unlikely. Accordingly, the rules do not violate the principle of "one man-one vote." However, in order to clarify this procedure and address the commenter's concerns, the rules have been changed upon adoption to provide that neither the LAD carrier representative, nor any affiliate of the LAD carrier, may otherwise be a member of the governing committee. A definition of "affiliate" was added at N.J.A.C. 11:3-2.2.

Secondly, the goal of representation on the governing committee is not merely to permit people who are compelled to participate in the PAIP to have a say in its operation. Producers and the general public are in no way "compelled" to participate in the PAIP. While automobile insurance is compulsory, an individual's own driving actions will determine whether he or she is eligible for the voluntary market. Therefore, there is nothing "compelling" that person to be insured through the PAIP. Similarly, producers are not "compelled" to participate in the PAIP. The Department believes that it is reasonable and appropriate to provide for representation on the governing committee by entities or persons that have an interest in, and may be directly affected by, the decisions of the governing committee. As noted in the proposal Summary, the Department believes that since LAD carriers may be subject to additional requirements when performing in their capacity as a LAD carrier, it is both reasonable and appropriate to permit a LAD carrier representative on the governing committee.

Thirdly, the Department does not believe that any direct conflict of interest arises. There is a potential conflict in any action by the governing committee since it is comprised of representatives who have a direct interest in, and will directly be affected by, the PAIP's operation. Insurers decide matters on the governing committee that will directly affect their obligations. Moreover, the governing committee's authority to approve LAD carrier contracts could not be used to exclude a LAD carrier representative. Pursuant to N.J.A.C. 11:3-2.11(i), as amended, the governing committee as well as the Commissioner approves the "basic contract" to be utilized for all LAD carrier arrangements. Substantive modifications are also submitted to the governing committee and Commissioner for approval. Further, approval of the contract is not required to become eligible to act as a LAD carrier pursuant to the LAD Program Manual and Plan of Operation. Finally, the Department notes that the LAD carrier representative will have only one vote and therefore the ability to approve contracts or LAD carriers in its favor to the detriment of others would be minimal.

Fourthly, while PAIP governing committee meetings are open to the public and any person may participate, only members of the governing committee have the right to vote. As noted previously, the Department believes that it is reasonable and appropriate to provide direct representation and the ability to vote on matters before the governing committee by those persons directly affected by their decisions.

Finally, the Department does not believe that it would be reasonable or appropriate to allocate the nomination process by market share. While under this scheme the commenter undoubtedly always would be represented on the governing committee, this would effectively preclude any smaller carrier from ever being represented.

For the foregoing reasons, the Department has determined that no change is required.

COMMENT: One commenter disagreed with the Department's determination to not specifically exempt "de minimis" companies (that is, insurers with less than 1,000 exposures). The commenter stated that it is a small mutual insurer that was required by the Department to write two private passenger automobile exposures in 1991. The commenter stated that it does not voluntarily write personal private passenger automobile insurance in any state where it is licensed, and has just completed a withdrawal from this line in another state. The commenter stated that it does not intend to become an active participant in the personal private passenger automobile line of business in any jurisdiction in the foreseeable future.

Accordingly, the commenter believes that the "safety valves" cited by the Department in the proposal Summary (for example, the ability of insurer to transfer its obligations to accept PAIP assignments through a LAD carrier arrangement and the credits for voluntary writing) will not avoid any undue burden being placed on this carrier. The commenter stated that the voluntary writing credit presumes that a carrier intends to remain in the private passenger automobile insurance line. Moreover, the commenter stated that entering into a LAD agreement carries with it many costs associated with the requirements of N.J.A.C. 11:3-3.5. Among the costs cited by the commenter are costs of the buy-out agreement, the costs of the annual independent financial audit, the costs of semi-annual on-site reviews, and the costs of obtaining actuarial opinion. The commenter believes that the suggested means to relieve small carriers of the burden of PAIP by either requiring a company to write more business or enter into an administratively costly LAD program does not provide "true" relief.

For these reasons, the commenter requested that the Department consider an outright exemption for those carriers that are not active participants in the New Jersey personal private passenger automobile insurance market. Recognizing objections raised previously with respect to the "de minimis" exemption, the commenter suggested as an alternative, exemption of those carriers with less than 100 exposures and less than $100,000 of annual written premiums, and exemption of carriers that can demonstrate to the Department's satisfaction that the company was not an active writer of private passenger automobile insurance as evidenced by decreasing exposure and written premium data over a period of time prior to implementation of the Fair Automobile Insurance Reform Act of 1990, and whose current book of business is less than 500 exposures.

Conversely, one commenter explicitly supported the requirement that all insurers participate in the PAIP, including "small insurers." The commenter stated that these insurers should be required to share in the responsibility of serving the assigned risk market to the same proportionate extent as large insurers. The commenter noted that the Department stated in its proposal summary that any insurer may transfer PAIP obligations to another member insurer pursuant to the PAIP rules.

RESPONSE: Upon review of the commenter's concerns, the Department has determined not to change this provision. As noted in a response to a previous comment, the Department believes that it is reasonable to require that all automobile insurers participate in the PAIP to the extent of their participation in the voluntary market. As the commenter stated, it has written only two private passenger automobile exposures. Since participation in the PAIP is directly tied to market share, the number of exposures, if any, that would be assigned to the commenter through the PAIP would be exceedingly small.

Moreover, the commenter has apparently misinterpreted the requirements with respect to LAD buy-out arrangements. The commenter stated that it would be required to comply with N.J.A.C. 11:3-3 in order to "buy-out" of its obligations. These rules, however, relate to LAD servicing carrier relationships, which differ from LAD carrier arrangements. In a LAD servicing carrier arrangement, the insurer generally remains liable for the risk and the assignment, but utilizes other entities to perform substantially all of the underwriting or claims processing for those risks. In a LAD carrier arrangement, the member insurer has transferred the entire obligation to another member insurer. While there will be costs involved in the buy-out agreement, the requirements governing such arrangements are not set forth in N.J.A.C. 11:3-3 but rather in the LAD Program Manual and the PAIP Plan of Operation.

Nevertheless, as noted previously, if a "de minimis insurer" should decide not to buy-out of its obligations, the Department believes that no undue burden should be imposed. Since PAIP assignments are generally tied to market share, an insurer such as the commenter, with very few exposures, will not receive a significant number of exposures through PAIP, if indeed it is assigned any exposures.

COMMENT: One commenter stated that since its formation it has issued policies only with a $15,000/$30,000 liability limit. The commenter stated that it believes that the PAIP rules may require it to issue policies with significantly higher limits. The commenter believes that this could put the company in "an extraordinarily vulnerable position" if it is required to pay one or more PAIP claims for those significantly higher limits. The commenter therefore requested that the proposed rules be modified to limit the obligation that it or similarly situated companies write higher limits than they are currently writing in this State.

RESPONSE: The Department notes that the requirement that increased limits be offered by the PAIP is currently required under N.J.A.C. 11:3-2.7, effective September 21, 1992. This proposal does not affect that provision. Accordingly, the comment with respect to writing increased limits is outside the scope of this proposal.

In addition, the Department notes that a comment similar to that raised by the commenter was considered and rejected by the Department in the adoption of the PAIP rules (see 24 N.J.R. 3403).

Moreover, if the commenter believes that its financial condition is threatened or may be threatened as a result of receiving PAIP assignments in accordance with the rules it may request relief from its obligations pursuant to N.J.S.A. 17:33B-23, 17:33B-24 and N.J.A.C. 11:2-35. The Department also notes that N.J.A.C. 11:3-2.11(a)5 provides that no insurer whose surplus as regards policyholders is less than $1.5 million will be assigned a risk requesting or required by law to carry limits in excess of 50/100/10. The Department believes that these provisions should eliminate any undue burden that may be imposed on member insurers.

COMMENT: One commenter suggested that N.J.A.C. 11:3-2.5(a)4 be expanded to make clear that a LAD carrier representative would be rotated so that each year a representative from a different LAD carrier is appointed to the governing committee. The commenter stated that selection of which LAD carrier would provide a representative may be made by the remaining members of the governing committee so that no single LAD carrier can have a representative for two or more consecutive years unless there is only one LAD carrier. The commenter believes that this is reasonable to ensure that each LAD carrier will be given an opportunity to serve on the governing committee, subject to governing committee selection, and to ensure that the representation is not dominated by a single LAD carrier. Moreover, the commenter stated that the concept of rotation is consistent with the rotation used for insurers on the governing committee. Finally, the commenter noted that since LAD carriers, although insurers, represent a different group subject to additional specific requirements, rotation of LAD carrier membership on the governing committee would be appropriate, useful, and broaden perspectives, insight, and level of experience that will be useful to the governing committee, the Department, producers and the public.

RESPONSE: Upon review of the commenter's suggestion, the Department has determined not to change this provision. The Department initially notes that the changes suggested by the commenter could not be made upon adoption as all interested parties must be given notice and an opportunity to comment on such a change. Moreover, the Department notes that the current rules at N.J.A.C. 11:3-2.5 do not specifically provide for the rotation of governing committee members. Further, this rule provides that all members shall be appointed by the Commissioner, rather than the governing committee (see N.J.A.C. 11:3-2.5(e)). Accordingly, the commenter's suggestion that selection of the LAD carrier representative could be made by the remaining members of the governing committee would be inconsistent with the express terms of the rule. Moreover, the Department does not believe that the problems contemplated by the commenter should result in that any LAD carrier may nominate a person to be a representative on the governing committee. The Commissioner would appoint the representative to the governing committee from among the nominees. Nothing would prohibit the Commissioner from appointing or rotating the appointment of members to the governing committee that, in his or her opinion, satisfy the requisite knowledge and expertise requirements.

Full text of the adopted new rules follows (additions indicated in boldface with asterisks ***thus***; deletions indicated in brackets with asterisks *[thus]*):

11:3-2.2 Definitions

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

An "affiliate" of, or a person "affiliated" with, a specific person, means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

. . .

11:3-2.4 Exemptions

(a) Every insurer shall participate in the PAIP to the extent required by this subchapter and the plan of operation.

(b) The requirements of this subchapter shall not apply to the following:

1. Insurers that have not issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983;

2. Insurers that have issued or renewed policies of private passenger automobile insurance in New Jersey since December 31, 1983, but only in accordance with a commercial lines rating system filed and approved pursuant to N.J.S.A. 17:29AA-1 et seq.

3. Insurers transacting private passenger automobile insurance business in New Jersey subject to a plan of orderly withdrawal approved in accordance with N.J.A.C. 11:2-29, but only to the extent that waiver of participation in the PAIP is explicitly provided by the terms of the approved plan of orderly withdrawal; or

4. Insurers transacting private passenger automobile insurance business in New Jersey subject to an order issued by the Commissioner in accordance with N.J.S.A. 17:33B-23 and 24, but only to the extent provided by the terms of the order.

(c) Insurers that currently insure, or have insured since December 31, 1983, only certain types of automobiles (for example, motor homes, recreational vehicles, antique automobiles or motorcycles) shall participate in the PAIP but only for the particular types of automobiles currently being insured.

(d) Insurers claiming to be excluded from participation pursuant to the provisions of (b) or (c) above shall comply with the following:

1. Such insurers shall file with the PAIP no later than 60 days from the effective date of this rule a certified statement containing the following information:

i. The insurer's name, including the NAIC group number;

ii. A statement that the insurer is not required to participate in the PAIP or receive assignments through the PAIP;

iii. The factual basis upon which the insurer relied to determine that it is not required to comply fully with this subchapter;

iv. The particular provision of this rule under which the insurer is included; and

v. A certification by an officer of the insurer that the statement is complete, correct and accurate to the best of the officer's information, knowledge and belief based upon the officer's personal review of all relevant records.

2. The certified statement shall be sent to the PAIP at the following address:

PAIP Exemptions
New Jersey Personal Automobile Insurance Plan
2000 Midlantic Drive
Laurel Corporate Center
Suite 450
Mt. Laurel, NJ 08054

3. A copy of the information filed pursuant to (c)1 and 2 above shall be filed with the Department at the following address:

ARM Unit
New Jersey Department of Insurance
20 West State Street
CN-325
Trenton, New Jersey 08625-0325

11:3-2.5 Governing committee

(a) The PAIP shall be administered by a governing committee of 14 members.

1.-2. (No change.)

3. One member shall be a public representative who is knowledgeable about automobile insurance matters but who is not employed by, or otherwise affiliated with, insurers, insurance producers, or other entities of the insurance industry.

4. One member shall be a salaried employee of an approved LAD carrier for the PAIP*, **provided that neither the LAD carrier nor any affiliate of the LAD carrier otherwise serves as a member of the governing committee***.

5. (No change in text.)

(b) The following organizations shall each nominate two members to represent insurer participants of PAIP:

1.-3. (No change.)

(c) Insurers which are not members of the organizations in (b) above shall nominate two members to represent insurer participants in accordance with a fair method set forth in the plan of operation.

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

(g) The governing committee shall have the power and duty to:

1.-5. (No change.)

6. Investigate complaints and hear appeals from applicants, insureds, producers, LAD carriers, or insurers about any matter pertaining to the proper administration of the PAIP;

7.-12. (No change.)

11:3-2.6 Plan of operation

(a) The plan of operation shall provide for the prompt and efficient provision of personal private passenger automobile insurance to qualified applicants. The plan of operation shall provide for, among other matters:

1. (No change.)

2. Standards and procedures for:

i. (No change.)

ii. The appointment, compensation, and termination by insurers of LAD carriers (consistent with any requirements established by regulation by the Commissioner);

3. Performance standards for insurers, producers, LAD carriers, the PAIP manager, and other employees, professionals and contractors required to administer the PAIP;

4.-11. (No change.)

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

11:3-2.11 Determination and fulfillment of quotas

(a)-(h) (No change.)

(i) The governing committee shall establish procedures in the plan of operation permitting an insurer by mutual agreement to transfer its obligations to accept assignments to another insurer (to be known as a LAD carrier). The basic contract to be entered into between insurers and LAD carriers, including the minimum duration of such agreement, shall be approved by the governing committee and the Commissioner. Any substantive modifications to the approved contract shall be submitted to the governing committee and Commissioner for approval prior to its use. With respect to the transfer of an insurer's obligations to accept assignments to a LAD carrier, the plan shall address the following:

1.-6. (No change.)

11:3-2.12 Right to petition for appeal to the Commissioner

(a) An applicant, insured, producer, LAD carrier, person applying to act as a LAD carrier, or insurer may petition for appeal to the Commissioner from an adverse decision of the governing committee by filing a request in writing within 20 days of the date of receipt of the written decision of the governing committee.

1.-3. (No change.)

(b) (No change.)

(a)

UNSATISFIED CLAIM AND JUDGMENT FUND

Unsatisfied Claim and Judgment Fund's Reimbursement of Excess Medical Expense Benefits Paid by Insurers

Adopted Amendments: N.J.A.C. 11:3-28.4 and 28.6
Adopted New Rules: N.J.A.C. 11:3-28.1, 28.2, 28.10 through 28.13, and Appendices A and B
Adopted Repeal and New Rule: N.J.A.C. 11:3-28.1

Proposed: June 21, 1993 at 25 N.J.R. 2636(b).

Adopted: October 21, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: October 21, 1993 as R.1993 d.583, **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. 17:1C-6(e) and N.J.S.A. 39:6-1 et seq.

Effective Date: November 15, 1993.

Expiration Date: January 4, 1996.

Summary of Public Comments and Agency Responses:

The proposed new rules, amendments and repeal were published on June 21, 1993 at 25 N.J.R. 2636(b). During the comment period which closed July 21, 1993, seven comments were submitted from insurance companies (Allstate Insurance Company. First Trenton Indemnity Company, Motor Club of America, New Jersey Manufacturers and The Prudential Property and Casualty Insurance Company), an insurance trade association (American Insurance Association) and a claims handling agent (Material Damage Adjustment Corporation of New Jersey). These comments and the Department's responses are summarized below:

COMMENT: Several commenters objected to the definition of "medically necessary." One commenter suggested that the definition as set forth at N.J.A.C. 11:3-28.2 is too narrow and contrary to the Unsatisfied Claim and Judgment Fund ("UCJF") and no-fault laws. The commenter claimed that insurers are to ignore all medical expense benefit payments in excess of $75,000 in the rate making process because rating rules assumes that insurers are reimbursed for all payments in excess of $75,000. Therefore, the commenter suggested that the denial of reimbursement for payments other than those which are medically necessary is an unconstitutional taking and that the definition should be revised to conform with the definition of medical expense benefits.

Another commenter suggested that within the definition of medically necessary, the Fund should define which services are "needed" and are "commonly and customarily recognized" throughout the medical profession.

RESPONSE: The definition of medically necessary, as defined in this subchapter, merely codifies the Fund's standard practice in determining which expenses are necessary medical expenses. It would be impossible to enumerate in the definition of medically necessary an exhaustive list of all services which are deemed to be needed or which are commonly and customarily recognized throughout the medical profession. In accordance with past practice, if there is uncertainty on the part of the insurer, as to which benefits are medically necessary, it may contact the Fund for clarification. The fact that an insurer cannot be reimbursed for payments which should not have been made does not constitute an "unconstitutional taking." As a prudent business practice, insurers conduct audits to determine whether medical expenses are necessary. This subchapter, under certain circumstances, requires insurers to perform initial on-site audits to determine the necessity of services. Where an insurer fails to conduct such necessary audits and it is later determined that certain expenses are not medically necessary, it cannot pass-on these costs to the Fund.

COMMENT: One insurer suggested that the definition of diagnostic related groups ("DRG") should be eliminated from N.J.A.C. 11:3-28.2 because as of January 1, 1993, DRGs have no longer been in use.

RESPONSE: Currently, DRGs comprise the basis of the majority of the bills received by the Fund and may continue to appear in bills for the next few years. Therefore, the definition is relevant.

COMMENT: One commenter suggested amending the definition of "health care services" to require that all health care facilities comply with all medical board rules and regulations governing the licensing and ownership of the facilities and the services which they provide.

RESPONSE: The Fund does not have the jurisdiction to amend the definition of health care services. Moreover, the Fund lacks jurisdiction to enforce such requirements and such an amendment is beyond the scope of these rules.

COMMENT: One commenter suggested that the Fund establish an advisory committee to review and provide guidelines for insurers to follow; to establish an informal appeal procedure for insurers whose claims are denied; and from which to obtain prior approval of a claim where the insurer is uncertain as to whether reimbursement is appropriate.

RESPONSE: The Fund does not have statutory authority to implement such an advisory committee. However, as noted above, the Fund may be contacted to clarify any points of uncertainty.

COMMENT: One commenter suggested that insurers should be entitled to interest, attorney fees and punitive damages where these costs are incurred as a result of delay on the part of the Fund, contrary to the provisions of N.J.A.C. 11:3-28.7(a).

RESPONSE: N.J.A.C. 11:3-28.7(a) (formerly 28.6), as originally drafted, denied such costs. The purpose of the amendment to this section is to permit insurers to submit requests for reimbursement for payment of excess medical expense benefit claims which were inadvertently omitted from quarterly submissions, but only for a period of one year from the date of payment by the insurer.

Historically, any delay with regard to such claims which may have occurred in the past, was due in part to the Fund's lack of internal procedures and lack of automated systems and in part to the insufficiency of information provided by insurers. Over a period of years, the Fund has developed internal operating procedures and has also automated its processing procedures. The amendment which the commenter has suggested is, therefore, unwarranted and, nevertheless, beyond the scope of these rules.

COMMENT: One commenter suggested that N.J.A.C. 11:3-28.7(a)1 should specify that the provision only applies to claims opened after the effective date of any new requirements.

RESPONSE: The amendment to N.J.A.C. 11:3-28.7(a)1 merely codifies the current practice of the Fund. The suggested clarification is therefore improper.

COMMENT: Another commenter claimed that implementation of N.J.A.C. 11:3-28.7(a)1 may cut off legitimate requests for reimbursement, where a claimant incurred a medical expense more than one year after the date of payment by the Fund and the insurer is required to pay such medical expenses after a gap in treatment of more than one year.

RESPONSE: The commenter misunderstood the amendment. An insurer may submit a request for reimbursement for a period of one year from the date the insurer paid the claim, even if the request for reimbursement results from a claim for treatment after a one-year gap in treatment.

COMMENT: One commenter recommended that N.J.A.C. 11:3-28.7(a)1 should be clarified to indicate that the denial only applies to the specific reimbursement requested, not the entire quarterly submission. Another commenter suggested that the additional period in which to file a claim with the Fund should be increased to two years to correspond with the two-year statute of limitations for litigation of such claims as well as the two year period for filing a claim under the no-fault law.

RESPONSE: The Department concurs with the recommendation that N.J.A.C. 11:3-28.7(a)1 should be amended to clarify that the denial only applies to the specific reimbursement request. N.J.A.C. 11:3-28.7(a) is, therefore, amended to read:

> Failure to comply with the requirement's set forth in (a)1 above, shall result in a denial **by the Fund** of [reimbursement] **the reimbursement request which was omitted from the quarterly submission.** [by the Fund].

With regard to increasing the time in which to file a claim, the statute of limitations for litigation does not apply to administrative claims handling. Increasing the period for "forgotten" claims would improperly permit the filing of stale claims.

COMMENT: Several commenters claimed that the 20 percent self-executing reduction in reimbursement for unaudited bills, as provided at N.J.A.C. 11:3-28.10(a)1, is a penalty; that the 20 percent reduction is arbitrary and unreasonable; that the justification for the 20 percent reduction is based upon DRG billing which is no longer in existence and the percentage is, therefore, inappropriate; and that insurers should be afforded due process rights with regard to the imposition of any penalty.

Another commenter suggested that if an insurer fails to perform an audit, the Fund should initiate the audit through a responsible auditing firm. Where the audit substantiates the fact that a reduction is appropriate, the reduction should be deducted from the amount submitted for reimbursement and the insurer should be charged a flat fee for the audit. Another commenter claimed that only 10 percent of claims are found to be non-reimbursable following audits.

RESPONSE: For reimbursement by the Fund, N.J.A.C. 11:3-28.10(a) requires insurers to conduct investigations and audits of claims submitted by health care facilities equal to or in excess of $25,000. The 20 percent reduction in payment, where an insurer fails to comply with an audit, is not a penalty. The amount is not arbitrary and unreasonable. It is a conservative estimate of the amount of claims which are generally determined to be non-reimbursable subsequent to an actual audit. This information is based on adjusting company data and is not based solely on DRG rates as alleged by the commenter. DRG billings, while no longer in effect will, nevertheless, continue to appear in insurer claims for reimbursement in the future.

Because the 20 percent reduction is not a penalty, but merely a conservative estimate of the value of unsupported or unjustified claims, a hearing is not required where such a reduction is effected. Moreover, insurers can avoid any such reduction in payment by simply conducting the audits which are necessary, reasonable and required by these rules.

The alternative audit procedure suggested by one commenter would create excessive administrative burdens on Fund employees, while excusing certain recalcitrant insurers from performing their responsibilities in accordance with this subchapter. The overall effect would be a burden on policyholders. This alternative would also unnecessarily deplete the Fund's limited assets. The 20 percent reduction has been determined to be reasonable and appropriate. This percentage reduction was unanimously approved by the Fund's Board and Advisory Committee in June 1993.

COMMENT: One commenter claimed that often bills are not audited because they "fell through the cracks." In such cases insurers should be permitted to conduct post-payment audits to demonstrate that payments were justified. The commenter suggested that only where an insurer frequently fails to conduct audits, so as to indicate a general business practice, would it be appropriate to impose penalties on the insurer.

RESPONSE: As noted above, the 20 percent reduction in reimbursements is not a penalty but a recognition that approximately 20 percent of audited bills are non reimburseable. To permit insurers to conduct post-payment audits would discourage insurers from conducting timely audits; would unnecessarily deplete the Fund's resources; and would create an uncertainty as to the Fund's actual resources. Requiring a pre-payment audit serves to promote administrative ease and accuracy and preserves the Fund's resources.

COMMENT: One commenter recommended that insurers be given 90 days rather than 60 days in which to provide an initial on-site audit to the Fund.

RESPONSE: The Fund concurs with this recommendation and amends N.J.A.C. 11:3-28.10(a)5 accordingly.

COMMENT: One commenter suggested that N.J.A.C. 11:3-28.10(c) should be clarified to provide that audits are required on cumulative bills issued by any single facility or provider rather than on cumulative bills of all facilities and providers on a single claim. Another commenter requested a clarification of this section.

RESPONSE: The commenter's interpretation of N.J.A.C. 11:3-28.10(c) is inaccurate. Insurers are required to perform audits on all claims submitted "per confinement" where the appropriate thresholds are, or will be met. The rule does not require further clarification because it is to be read literally.

COMMENT: One commenter claimed that N.J.A.C. 11:3-28.10(d) is improper because it would require insurers to guess, prior to receiving all bills, whether the total of all bills for continuous treatment will ultimately exceed the audit threshold.

RESPONSE: This rule merely codifies the current standard practice. This subchapter requires on-site audit for the reimbursement of certain claims. Where such on-site audits are conducted, insurers should submit the audits to the Fund. Moreover, insurers have sufficient expertise to conclude which injuries and which confinements will approach or exceed the audit threshold.

COMMENT: One commenter recommended that prior approval for modifications to a vehicle should only be required above a certain dollar amount.

RESPONSE: The Fund agrees with this comment and amends N.J.A.C. 11:3-28.11(b) to require prior approval for modifications to a vehicle only where the modifications are equal to or in excess of $1,000. Such amendment is beneficial both to insurers and the Fund. Insurers will be relieved from the prior-approval requirements for modifications under $1,000 and the Fund will not be burdened with the review and processing of such requests.

COMMENT: One insurer, citing N.J.A.C. 11:3-28.11(c)2, claimed that the rules appear to be inconsistent with the UCJF and no-fault laws because existing case law requires the payment of medical expense benefit payments based upon medical necessity rather than cost effectiveness.

One commenter claimed that the rules seem to imply that the Fund can deny reimbursement for financial considerations rather than medical necessity. Another commenter suggested that quality of life considerations should be a factor in the approval process of vehicle modifications.

RESPONSE: While claimants are entitled to receive medical expense benefits based on medical necessity, they are not entitled to any particular benefit. In order to preserve the Fund's assets, the Fund must be administered in a cost effective manner to ensure that all claimants receive appropriate benefits without improperly depleting the Fund's resources. Therefore, the Fund is justified in determining whether other more cost effective benefits are appropriate in certain circumstances.

The statute does not authorize the approval of vehicle modifications based on quality of life considerations. Because the Fund's resources are limited and all eligible claimants must be covered, the Fund is not at liberty to expand its criteria for modifications.

COMMENT: One commenter suggested that the time-consuming prior approval process required by N.J.A.C. 11:3-28.12 is antithetical to good management, as the needs of individuals are better met in a quick manner, and that the insurer can sufficiently determine the cost benefit of modifications.

RESPONSE: The prior approval process is necessary to ensure that (1) the modifications are medically necessary and (2) the Fund's resources are safeguarded by conducting a cost-benefit analysis, which is a necessary management practice. It is, therefore, essential that insurers comply with this prior-approval process. Moreover, in the past, this practice has resulted in efficient transactions for affected claimants.

COMMENT: One commenter suggested that N.J.A.C. 11:3-28.12 should be amended to provide the insurers be permitted to seek an exception from the rule. It also suggested that modifications to rental properties be kept to a minimum and should be temporary in nature. Claimants should also be encouraged to seek rental housing accessible to the handicapped where available.

RESPONSE: The rules do not prohibit insurers from seeking exceptions from the rules. However, because the Fund's resources are limited, it is unlikely that many, if any, exceptions would be granted. Because the Fund strives to operate in a cost-effective manner, it does encourage minimal alterations to rental property and that claimants seek accommodations for the physically impaired, when available.

COMMENT: One commenter expressed its concern that requiring the repayment of the unamortized costs of modifications, upon the death of a claimant, may force families to sell their homes to reimburse the Fund.

RESPONSE: The Fund does not envision that the survivors, which own the residences, would be required to sell their homes because the Fund's assets are protected by virtue of the lien filed against the premises.

COMMENT: An insurer recommended that N.J.A.C. 11:3-28.11(d) and 28.12(d) should be amended to incorporate safeguards to protect insurers from arbitrary and capricious decisions by the Fund which would require insurers to obtain independent evaluations from physicians at the insurers' cost.

RESPONSE: These provisions merely codify the current practice, which is within the Fund's general authority. The Fund examines each request on a case-by-case basis. The Fund has rarely required an insurer to obtain an independent evaluation from a physician. Generally the Fund has only made such requests when there has been some doubt over a course of treatment; for example, if there has been overtreatment or unnecessary treatment performed. In such instances the Fund has requested an independent physician's evaluation to ensure that there has not been any fraud or collusion on the part of a treating physician and his or her patient. The Fund has also requested independent physicians' evaluations where claim files have become stale.

Such evaluations are rarely ordered and are generally only for the above reasons. The Fund does not require such evaluations arbitrarily or capriciously. Further amendments to N.J.A.C. 11:28.11(d) and 28.12(d) are, therefore, unnecessary.

COMMENT: One commenter suggested that N.J.A.C. 11:3-28.12(g) should provide that the Fund be named as a co-lienholder.

RESPONSE: The Fund has determined that the additional expense to both the Fund and policyholders is unnecessary in light of the adequate performance of insurers in recouping monies from claimants.

COMMENT: One commenter suggested that, pursuant to N.J.A.C. 11:3-28.13(a), the denial of reimbursement to insurers for paid medical expense benefit claims should be limited to damages that could have reasonably been recovered from a responsible tortfeasor.

Another commenter claimed that obtaining prior approval from the Fund for compromising settlements of PIP right of recovery actions is inappropriate. The commenter accused the Fund of being unreasonable by refusing to accept less than 100 percent of full payments.

RESPONSE: The standard set forth at N.J.A.C. 11:3-28.13 is clear and consistent with past practice; insurers are required to diligently pursue a right of recovery or to obtain prior approval from the Fund before settling or compromising a claim against a tortfeasor.

The Fund disagrees with the commenter's characterization that the Fund is unreasonable. The Fund considers each case individually. Generally the Fund works in concert with insurers and their counsel by discussing and considering an insurer's case strategy and resources and weighing the benefits of settlement against the costs of litigation and the probability of success of litigation.

COMMENT: One insurer suggested that the Fund should share with insurers in the expenses incurred in pursuit of a bona fide claim for damages against tortfeasors. Another commenter concurred and also stated that the rules on home and vehicle modifications require each insurer to provide adjusting services, auditing services and rehabilitative care management and also require expenditures for expert fees and legal services. The commenter suggested that the Fund should also share in these expenses.

RESPONSE: Requiring the Fund to share in the above-noted expenses would be contrary to statute, would require additional resources to monitor any claims for the above-noted expenses and would deplete the Fund's resources for other than its intended purpose.

COMMENT: One commenter suggested that the requirement of N.J.A.C. 11:3-28.10(a)3, that insurers conduct initial on-site audits, is unnecessary and costly where "general hospitals" are concerned and that these hospitals should be excluded from the audit requirement. The commenter believes that the audits are unnecessary because the level of care and quality of services provided are well regulated by the Joint Commission of Accreditation for Hospitals and the Department of Health.

RESPONSE: The Fund acknowledges that "general hospitals" are well regulated with regard to the level and quality of care for purposes of an individual's well being. However, the Fund is concerned with the accuracy of the billings submitted for reimbursement. The Fund, therefore, rejects the commenter's recommendation to exclude "general hospitals" from the audit requirement.

COMMENT: One commenter seeks comment on the scenario where a 19 year old has suffered permanent injuries and the parents prefer home care to placing their child in a long-term care facility. The commenter suggests that the Fund would direct the parents to place their child in a facility in order to obtain reimbursement from the Fund.

RESPONSE: The Fund has never directed such a result. Notwithstanding the Fund's limited resources, the Board has discretion to approve alternative care choices.

COMMENT: One commenter supported the position of paying a provider facility a "good faith" payment of 80 percent of the invoiced amount prior to conducting a formal audit of charges submitted.

RESPONSE: The rules do not dictate the amount an insurer can pay prior to audit. The rules do, however, provide the percentage of claims which will not be reimbursed if an insurer fails to conduct an audit.

COMMENT: One commenter suggested that notwithstanding that some medical providers do not comply with the New Jersey Medical Fee Schedule at N.J.A.C. 11:3-29, that Fund claims handlers should review bills in accordance with N.J.A.C. 11:3-29.

RESPONSE: The medical fee schedule set forth at N.J.A.C. 11:3-29 is observed by Fund claims handlers when applicable. However, it is the insurer's primary responsibility to insure compliance with the New Jersey Medical Fee Schedule.

COMMENT: One commenter claimed that the use of independent experts to assist in the design of home modifications, and the need to secure counsel to complete the necessary contracts between insurers and claimants, without reimbursement to the insurer, is unfair.

RESPONSE: The additional expenses are reasonable and necessary and ultimately serve to preserve the Fund's assets. Modifications for use by the physically impaired is a highly specialized field which requires expertise in several areas including, but not limited to, fire safety, building codes and zoning requirements. Past practice has proven that the use of experts is cost effective.

The costs associated with the preparation of legal documents is also a necessary and reasonable expense for the purpose of protecting the Fund's interests and resources as well as the interests of the claimants. These costs are properly borne by insurers.

COMMENT: Several commenters seek to utilize their own forms rather than the forms required in accordance with this subchapter.

RESPONSE: The Fund requires the submission of information on its own forms. This requirement is for administrative convenience and efficiency in order to facilitate locating necessary information and to limit the type of information filed, to only that information which is necessary for the Fund's evaluation.

Summary of Agency-Initiated Changes.

In N.J.A.C. 11:3-28.12(c)3, the phrase "in acceptance with Appendix B" has been corrected to "in accordance with Appendix B."

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

11:3-28.1 Purpose and scope

(a) The purpose of this subchapter is to establish procedures to ensure that only appropriate, reimburseable claims are submitted to the Fund by insurers by requiring investigation of the medical necessity for certain claims; requiring the audit of claims of $10,000 or more submitted by licensed providers of health care services or claims of $25,000 or more by health care facilities; and requiring prior approval of claims for alterations to vehicles and residences. This subchapter also requires insurers to pursue the proper, alternative sources for reimbursement where such other sources of funds are available.

(b) This subchapter applies to all insurers authorized in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17-1.

11:3-28.2 Definitions

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

"Diagnosis related groups" or "DRG" means a patient classification scheme in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, age, surgical procedure, and other complications. Each DRG exhibits a consistent amount of resource consumption as measured by some unit (for example, length of stay or dollars).

"Excess medical expense benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A-4a which are in excess of $75,000 resulting from personal injury to any one person in any one accident.

"Fund" means the Unsatisfied Claim and Judgment Fund established pursuant to N.J.S.A. 39:6-61 et seq.

"Health care facility" means a facility or institution, whether public or private, engaged principally in providing services for diagnosis of treatment of pain, injury, deformity or physical condition, including, but not limited to, a general hospital, special hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, outpatient clinic, dispensary or residential health care facility.

"Health care service" means the preadmission, outpatient, inpatient and postdischarge care provided in or by a health care facility, and such other items or services as are necessary for such care, which are provided by or under the supervision of a physician for the purpose of diagnosis or treatment of pain, injury, disability, deformity or physical condition, including, but not limited to, nursing service, home care nursing and other paramedical service, ambulance service, service provided by an intern, resident in training or physician whose compensation is provided through agreement with a health care facility, laboratory service, medical social service, drugs, biologicals, supplies, appliances, equipment, bed and board.

"Insurer" means any person authorized or admitted in this State to write the kinds of insurance specified in paragraphs d and e of N.J.S.A. 17:17-1.

"Licensed nursing personnel" or "licensed nurse" means a nurse licensed by the New Jersey State Board of Nursing or the equivalent from another jurisdiction.

"Medical expense benefits" means medical expense benefits paid in accordance with N.J.S.A. 39:6A-4a.

"Medically necessary" means services or supplies including tests or examinations that are needed for the medical care of a diagnosed injury. To be considered "needed" a service or supply must be ordered by a licensed physician and be commonly and customarily recognized throughout the medical profession as appropriate in the treatment of the particular injury for which it was ordered. Neither educational, experimental nor investigational procedures will be deemed "needed" or "medically necessary" for purposes of these rules.

"Per diem" means a daily fixed charge which includes room and board and other fees for services and supplies.

"PIP coverage" means personal injury protection coverage as described at N.J.S.A. 39:6A-4.

"Person" means any individual, association, company, corporation, insurer, joint stock company, organization, partnership, society, syndicate, trust, any combination of the foregoing acting in concert or any other entity.

"Pre-screen" means an off-site review of the billings from a health care facility to determine whether the care given and amounts charged are appropriate.

"Provider" means any person that furnishes services or equipment for medical expense benefits for which payment is required to be made under PIP coverage in automobile insurance policies, but does not include health care facilities.

"Reimbursement" refers to reimbursement to insurers by the Fund as provided at N.J.S.A. 39:6-73.1.

11:3-28.3 Report of such claims when the carrier has paid at least $50,000 for medical expense benefits

In cases where the potential exposure to the automobile liability insurer exceeds $75,000, the insurer shall report on form UC-321 (incorporated herein by reference as Exhibit 1 in Appendix A) whenever medical expense benefits in a total amount of $50,000 have been paid on account of personal injury to any one person in any one accident.

Recodify existing N.J.A.C. 11:3-28.3 as 28.4 (No change in text.)

11:3-28.5 Supplemental form to be submitted to the Fund

A two-sided reimbursement and reserve form, UCJF-REIMB./91 (incorporated herein by reference as Exhibit 2 in Appendix A), shall be filed with the Fund within 90 days after an automobile insurer has paid medical expense benefits on account of personal injury to any one person in any one accident in a total amount in excess of $75,000. Such form together with form UC-323(93) (incorporated herein by reference as Exhibit 3 in Appendix A) shall be filed each quarter that the insurer seeks reimbursement.

Recodify existing N.J.A.C. 11:3-28.5 as 28.6 (No change in text.)

11:3-28.7 Reimbursement of excess medical expense benefits paid by insurers

(a) Insurers shall submit to the Fund itemized accounts with supporting documentation of excess medical expense benefit claim payments as soon as practicable after the close of the quarter for which reimbursement is sought. The Fund shall reimburse automobile liability insurers for excess medical expense benefits on a quarterly basis. Insurers shall not be reimbursed for interest, attorney fees or punitive damages.

1. For a period of one year from the date of payment of a claim for excess medical expense benefits by an insurer, the insurer may submit to the Fund a request for reimbursement of a claim which was not included in the insurer's quarterly submission. The insurer shall include with its request, specific documentation to identify the subject payment.

2. Failure to comply with the requirements set forth in (a)1 above shall result in a denial ***by the Fund*** of *[reimbursement by the Fund]* ***the reimbursement request which was omitted from the quarterly submission***.

(b)-(d) (No change.)

Recodify existing N.J.A.C. 11:3-28.7 and 28.8 as 28.8 and 28.9 (No change in text.)

11:3-28.10 Insurers' obligations to investigate and audit bills for medical benefits

(a) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by health care facilities where such claims are equal to or in excess of $25,000.

1. Failure of an insurer to complete an audit in accordance with these rules shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

2. Per diem billings for health care facilities are not subject to the audit requirements set forth in this subchapter.

3. An insurer shall conduct an initial on-site audit for charges by health care facilities to determine whether the level of care, need and charges are appropriate.

4. An insurer may pay 80 percent of the provider's bill prior to completion of the initial on-site audit. The remaining amount due, if any, shall be paid following completion of the insurer's audit.

5. Annual on-site audits shall be completed in 12-month intervals, from the initial on-site audit and shall be filed with the Fund within *[60]* ***90*** days of completion of the audit; and

6. Whenever a change in services occurs such as, but not limited to, the level of care, the daily room rate or additional charges, an insurer shall conduct an on-site audit and shall provide the audit and auditor's statement to the Fund with the next reimbursement request.

7. All other audits shall be conducted prior to payment to the health care facility and may be performed on a pre-screen basis as set forth in (e) below.

(b) For purposes of reimbursement by the Fund, an insurer shall conduct an investigation and audit of claims submitted by providers where such claims are equal to or in excess of $10,000.

1. Failure of an insurer to complete an audit in accordance with this subchapter shall result in a 20 percent reduction in payment to the insurer by the Fund of the unaudited, reimbursable bill.

(c) The thresholds in (a) and (b) above are cumulative for each confinement associated with damages resulting from bodily injuries arising out of the ownership, maintenance or use of a motor vehicle in this State and shall incorporate all claims submitted per confinement by the health care facility or by each individual provider.

(d) To be eligible for reimbursement by the Fund, insurers shall audit, prior to payment, bills submitted for continuous treatment from any health care facility or provider which exceed or may exceed the applicable threshold.

(e) Audits of all providers and health care facilities conducted pursuant to this subchapter, including the audit of DRG bills and any successor pricing, shall be performed by:

1. Licensed nursing personnel with two years experience or training in required auditing and hospital practices; or

2. An outside auditing firm retained by the insurer for such purposes.

(f) Audits performed shall include, but not be limited to, confirmation of compliance with the medical fee schedule set forth at N.J.A.C. 11:3-29 including those situations where the insurer does not provide the primary coverage to the claimant.

(g) An insurer is not required to conduct a separate, independent audit, if it has obtained a true copy of an audit conducted by the primary insurer or health insurer.

(h) Insurers shall append copies of audits conducted, including those conducted by the primary insurer or health insurer, and the auditor's statements with the reimbursement request filed with the Fund in accordance with N.J.A.C. 11:3-28.7.

11:3-28.11 Modifications to vehicles

(a) An insurer shall obtain prior approval from the Fund for modifications to a claimant's vehicle, or vehicle to be used for the benefit of the claimant, the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications ***which are equal to or in excess of $1,000***, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. Where the claimant is the operator of the vehicle, current findings on the claimant's physical ability to drive and a copy of the claimant's current driver's license;

ii. A brief analysis of the medical necessity and medical purpose for the requested modifications;

iii. A description of the purpose for which the vehicle will be used; and

iv. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. A cost benefit analysis, supported by appropriate documentation, comparing the cost of modifying the claimant's vehicle to the cost of alternate methods of transporting the claimant. This analysis shall incorporate an evaluation of the anticipated miles to be driven per year for medically necessary health care services, including a breakdown reflecting the number of miles to be driven to obtain health care service and the frequency of such services, the cost per mile of alternate means of such transportation, as well as the useful life of the vehicle;

3. An agreement between the insurer and the claimant setting forth, but not limited to:

i. The claimant's responsibility to maintain insurance on the vehicle; and

ii. The claimant's responsibility to repair and maintain the vehicle; and

4. Any additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity and medical purpose exist for modifications to the vehicle. The evaluation shall include a review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a vehicle unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident, are required for a medical purpose and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modifications may be denied for failure to fulfill any of the above conditions.

11:3-28.12 Modifications to a claimant's residence

(a) An insurer shall obtain prior approval from the Fund for any modifications to a claimant's primary residence the cost of which may be reimbursed by the Fund.

(b) An insurer shall submit a written request to the Fund, seeking approval of modifications which are equal to or in excess of $10,000, within 30 days of a claimant's request for modifications.

(c) A request to obtain prior approval from the Fund shall include the following:

1. A written recommendation for the modification by the claimant's primary care physician including:

i. A brief analysis of the medical necessity for the requested modifications; and

ii. Verification that the requested modifications are necessitated by injuries sustained by the claimant in the subject accident;

2. Medical documentation estimating the claimant's life expectancy;

3. A cost benefit analysis, supported by appropriate documentation, which establishes that the proposed modifications are more cost effective than long term residential care services. The analysis shall include, in *[acceptance]* **accordance* with Appendix B incorporated herein by reference, an evaluation based on the life expectancy of the claimant and a comparison between the costs of the modifications and home care to be provided, to the costs of other residential care alternatives;

4. An evaluation prepared by an independent consultant experienced in barrier free designs that sets forth the type of modifications required and the costs of such modifications;

5. An agreement setting forth the responsibilities regarding the obligations of the claimant, the owner of the property or both and the insurer for, but not limited to:

i. The claimant's or property owner's responsibility for:

(1) The expenses for upkeep of the residence;

(2) Maintenance of insurance on the property; and

(3) Repayment to the insurer in the event of the claimant's relocation, death or upon the sale of the modified premises; and

ii. The insurer's obligation to remove nonessential equipment;

6. A repayment agreement with an amortization provision which provides an amortization term and amount, once a modification is determined to be cost effective, calculated in accordance with the formula provided in Appendix B to this subchapter; and

7. Any other additional information specifically requested by the Fund with regard to a particular application for approval.

(d) The insurer may independently evaluate, or be required by the Fund to evaluate, the claimant by a physician chosen by the insurer and approved by the Fund, at the insurer's cost, to determine whether a medical necessity for the modifications exist. The evaluation shall include a review of the elements considered in the primary evaluation as set forth at (c) above.

(e) The Fund shall not approve modifications to a residence unless it is demonstrated that the modifications are required for purposes of medical necessity resulting from injuries sustained by the claimant in the subject accident and the modifications are shown to be cost effective or as the Fund may otherwise determine.

(f) A request for modification may be denied for failure to fulfill any of the above requirements.

(g) Where a request for modifications is approved, the insurer shall record a lien against the modified property in the county in which the property is located and shall file a copy of the recorded lien with the Fund within 30 days.

1. This provision shall not apply to rental property.

(h) Where a claimant seeks to modify rental property, the insurer shall obtain:

1. A written consent from the owner of the property which permits the modifications and indemnifies the insurer and the Fund from any other liabilities relating thereto; and

2. A written agreement between the claimant and the insurer, in which the claimant agrees to reimburse the insurer for the unamortized costs of the improvements in the event of the claimant's relocation or death.

(i) Upon the claimant's relocation or death, the claimant, the claimant's estate or the owner of the property against which the lien is recorded, shall reimburse the insurer for the unamortized cost of the modifications to the claimant's residence.

(j) The claimant, the claimant's estate or the owner of the property against which the lien was recorded, shall have a reasonable period in which to reimburse the insurer.

(k) Where repayment by the claimant or the claimant's estate is required pursuant to this section, interest shall accrue at the prevailing rate of post judgment interest as set forth in the rules governing civil practice in the New Jersey Court Rules in effect at the time of execution of the repayment agreement, until the amount owed is paid in full.

(l) Within 30 days from the date of the claimant's relocation or death, the insurer shall so notify the Fund in writing and shall include the terms of repayment by the claimant to the insurer. The insurer shall repay the Fund for such reimbursement.

1. The insurer shall be required to repay the Fund within 60 days from receipt of any and all partial payments or from the receipt of a payment made in full by the claimant.

(m) A warrant discharging the lien shall be filed by the insurer when the full amount owed to the insurer, in accordance with the amortization agreement, is satisfied.

11:3-28.13 Insurer's obligation to obtain recovery of payments for paid medical expense benefit claims

(a) The Fund shall deny reimbursement to insurers for paid medical expense benefit claims if an insurer has failed to pursue any and all responsible tortfeasors within the time prescribed by law at N.J.S.A. 39:6A-13.1.

1. An insurer's failure to diligently pursue its right of recovery of medical expense benefit claim payments shall result in the denial of reimbursement by the Fund for these claims.

2. The Fund shall recover any reimbursement payments which were made to an insurer, where the insurer failed to diligently pursue its right of recovery against a tortfeasor.

3. An insurer shall obtain prior approval from the Fund before settling or compromising a claim against a tortfeasor.

(b) Any and all expenses and fees incurred by the insurer as a result of the pursuit of a right of recovery against a tortfeasor, shall be borne by the insurer.

APPENDIX A
EXHIBIT 1

UNSATISFIED CLAIM AND JUDGMENT FUND
EXCESS MEDICAL BENEFITS FIRST NOTICE FORM

This form shall be completed by the Carrier anticipating reimbursement from the Fund of Medical Expense Benefits. This form shall be sent to the Fund at the time the Carrier has made payments in a total amount of $50,000 and the Carrier expects the payments will exceed a total of $75,000.

PLEASE PRINT OR TYPE

NAME OF CARRIER UNDER WHICH POLICY IS WRITTEN NAIC NUMBER

ADDRESS

CITY STATE ZIP CODE

CONTACT PERSON

TELEPHONE NUMBER INCLUDING AREA CODE

CARRIER FILE NUMBER

CARRIER POLICY NUMBER

POLICY EFFECTIVE DATES
FROM: _____
TO: _____

DATE OF ACCIDENT

LOCATION OF ACCIDENT INCLUDING CITY, COUNTY AND STATE

NAME OF NAMED INSURED ON POLICY

NAME OF INJURED PARTY

ADDRESS

AGE OF INJURED PARTY AT TIME OF ACCIDENT SEX

DESCRIPTION OF INJURIES

PROGNOSIS AS TO INJURIES

AMOUNT OF MEDICAL PAYMENTS MADE TO DATE: $

TOTAL AMOUNT OF EXPECTED FUTURE MEDICAL PAYMENTS: $

RECOMMENDED RESERVE FOR THE TOTAL VALUE OF THE CLAIM TO ITS ULTIMATE DISPOSITION:
$_____.
RECOMMENDED RESERVE FOR THE AMOUNT OF PAYMENTS TO BE MADE IN THE NEXT TWO YEARS:
$_____.
DATE ON WHICH THE $75,000 THRESHOLD MAY BE REACHED: _____.

NAME OF SUPERVISOR RESPONSIBLE FOR INVESTIGATION FILE AND PHONE NUMBER:

COMPLETED BY _____ TITLE _____

PHONE NUMBER _____ DATE _____

UC-321 (R1/91)

EXHIBIT 2

UNSATISFIED CLAIM AND JUDGEMENT FUND
REIMBURSEMENT AND RESERVE FORM

This form shall be completed by the Carrier seeking reimbursement from the fund for Medical Expenses Benefits in excess of $75,000. The reverse side of this form must be completed upon submission of the first request for reimbursement only. A separate form shall be submitted with each request.

PLEASE PRINT OR TYPE

NAME OF CARRIER UNDER WHICH POLICY IS WRITTEN ADDRESS	CARRIER'S FILE NUMBER
NAME OF INJURED PARTY	EMB FILE NUMBER

SET FORTH PROGNOSIS AS TO INJURIES AND EXPECTED FUTURE MEDICAL PAYMENTS

RECOMMENDED RESERVE FOR TOTAL VALUE OF CLAIM TO ITS ULTIMATE DISPOSITION, NOT INCLUDING THE $75,000 THRESHOLD ..... $_____

TOTAL AMOUNT OF ANTICIPATED PAYMENTS DURING THE NEXT 2 YEARS ..... $_____

TOTAL AMOUNT OF EXPECTED PAYMENTS DURING THE NEXT 90 DAYS ..... $_____

THE PIP PAYMENT RECORD AND ADDING MACHINE TAPE(S) ARE TO BE ATTACHED TO THIS FORM. THE PIP PAYMENT RECORD SHOULD INCLUDE THE DATE PAID, AMOUNT PAID, NAME OF THE PARTY PAID AND TREATMENT DATES. THE PIP PAYMENT RECORD SHOULD INDICATE TO WHICH PAYMENTS THE PIP DEDUCTIBLE AND CO-PAYMENT WAS APPLIED.

AMOUNT OF REIMBURSEMENT NOW BEING SOUGHT FROM THE FUND ..... $_____

AMOUNT OF REIMBURSEMENT PREVIOUSLY RECEIVED, IF ANY ..... $_____

☐ NO FURTHER REIMBURSEMENT ON THIS CLAIM IS ANTICIPATED. WE HAVE CLOSED OUR MEDICAL EXPENSE FILE.

COMPLETED BY
TITLE
DATE COMPLETED
TELEPHONE NUMBER

*COMPLETE REVERSE SIDE ON INITIAL REQUEST FOR REIMBURSEMENT.

UCJF—REIMB./91

ANSWER THE FOLLOWING QUESTIONS "YES OR NO". IF AUDITS, MEDICAL REPORTS, ETC. ARE REQUIRED, ATTACH TO PIP PAYMENT RECORD AT TIME OF SUBMISSION FOR REIMBURSEMENT.

YES	NO	
_____	_____	CONCURRENCY APPLIES
_____	_____	WORKER'S COMPENSATION COVERAGE INVOLVED
_____	_____	SUBROGATION APPLIES
_____	_____	PIP REIMBURSEMENT OPTION SELECTED (IF YES, ATTACH COPY OF LETTER TO INSD)
_____	_____	CIB WAS FILED
_____	_____	AUDIT REPORTS FOR PAYMENTS OVER $10,000
_____	_____	COMPREHENSIVE MEDICAL AND/OR REHABILITATION REPORTS
_____	_____	PIP PAYMENT RECORDS WITH ADDING MACHINE TAPE(S).
_____	_____	COMPLETED AND SIGNED TREASURY INVOICE
_____	_____	IS CLAIM IN LITIGATION? IF SO, BY WHOM?

PLEASE STATE ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

UCJF-REIMB./91 p.2

EXHIBIT 3

UNSATISFIED CLAIM AND JUDGMENT FUND
EXCESS MEDICAL BENEFITS PAYMENT RECORD

CARRIER: _____ PAGE NUMBER: _____

CARRIER'S FILE NO.: _____ EMB FILE NO.: _____

INJURED PARTY: _____ DATE OF LOSS: _____

DATE RECEIVED	PROVIDER AND NATURE OF SERVICE	AMOUNT CHARGED	DATES OF SERVICE	AMOUNT PAID	DATE OF PAYMENT
			PAGE TOTAL:		

INDICATE WITH AN ASTERISK (*) NEXT TO THE PAYMENT OR PAYMENTS THE PIP DEDUCTIBLE COPAYMENT WAS APPLIED.

AN ADDING MACHINE TAPE WHICH CORRESPONDS WITH THE PAYMENTS LISTED SHOULD BE ATTACHED TO EACH PAGE. IF THERE IS MORE THAN ONE PAGE OF PAYMENTS SUBMITTED WITH THE REQUEST, A SEPARATE ADDING MACHINE TAPE SHOULD BE ATTACHED SUMMARIZING THE TOTAL OF PAYMENTS ON ALL OF THE PAGES.

C-323 (93)

APPENDIX B
AMORTIZATION FORMULA

The Fund shall evaluate the cost effectiveness of modifications to a residence and shall establish an amortization schedule based on information submitted to the Fund by the insurer. The insurer shall file with the Fund the information in categories (a) through (d) below. This information shall be accompanied by the documentation which supports the information in those categories. The factors which shall be considered by the Fund include:

(a) Cost of modifications;
(b) Annual cost of home care, including but not limited to, nursing care, therapy, transportation for medical treatment and medical supplies;
(c) Life expectancy of the injured person;
(d) Annual cost of other residential care alternatives;
(e) Monthly amount amortized; and
(f) Term of amortization in months.

1. The formula which the Fund shall evaluate to determine the cost effectiveness of requested home modifications is as follows:

$$(a + (b \times c)) < (d \times c)$$

The Fund shall only approve modifications where the above formula applies.

2. The formula to determine the amount to be amortized monthly is as follows:

$$(d - b)/12 = e$$

3. The formula to determine the term of the amortization schedule is as follows:

$$a/e = f$$

The following examples demonstrate how the formulas shall be applied:

	Example One	Example Two	Example Three
Cost of Modifications	100,000	100,000	100,000
Annual Cost of Home Care	60,000	6,000	60,000
Life Expectancy of Injured Party	30	10	20
Annual Cost of Other Residential Care Alternatives	84,000	120,000	60,000
Cost Effective Formula			
Cost for Home Care	1,900,000	160,000	1,300,000
Cost for Alternative Care	2,520,000	1,200,000	1,200,000
Is Home Modification Cost Effective?	Yes	Yes	No
Amortization Schedule			
Amount Amortized Monthly	$2,000	$9,500	
Term of Amortization	50 months	11 months	

(a)

DIVISION OF NEW JERSEY REAL ESTATE COMMISSION

Real Estate Commission Rules

Readoption: N.J.A.C. 11:5

Proposed: August 16, 1993 at 25 N.J.R. 3597(b).
Adopted: October 15, 1993 by the New Jersey Real Estate Commission, Micki Greco Shillito, Executive Director.
Filed: October 15, 1993 as R.1993 d.552, **without change.**

Authority: N.J.S.A. 45:15-6.

Effective Date: October 15, 1993.
Expiration Date: October 15, 1998.

Summary of Public Comments and Agency Responses:
No comments were received.

Full text of the readoption can be found in the New Jersey Administrative Code at N.J.A.C. 11:5.

(b)

DIVISION OF ENFORCEMENT AND CONSUMER PROTECTION

Notice of Administrative Correction
Insurance Fraud Prevention
Statement of Liability for Fraud on Claim Forms
N.J.A.C. 11:16-1.2

Take notice that the Office of Administrative Law has discovered an error in the current text of N.J.A.C. 11:16-1.2. The rule's requirement that, "Insurers must place the following warning on all claim forms:" was adopted as, "Insurers shall either place on or attach to all claim forms the following warning:" (see 20 N.J.R. 1062(a) and 1720(b)).

This notice of administrative correction is published pursuant to N.J.A.C. 1:30-2.7.

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

11:16-1.2 Statement of liability for fraud on claim forms

Insurers [must place the following warning on all claim forms] **shall either place on or attach to all claim forms the following warning:**

"Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

(c)

DIVISION OF LICENSING ENFORCEMENT AND CONSUMER PROTECTION

Managing General Agents

Adopted Concurrent New Rules: N.J.A.C. 11:17-6

Proposed: September 7, 1993 at 25 N.J.R. 4318(a).
Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.
Filed: October 15, 1993 as R.1993 d.563, **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. 17:1-8.1, 17:1C-6(e) and P.L. 1993, c.237.

Effective Date: October 15, 1993, Readoption of emergency rules;
November 15, 1993, Changes upon adoption.
Expiration Date: April 15, 1998.

These new rules were adopted on an emergency basis and concurrently reproposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4(c) (see 25 N.J.R. 4318(c)). The present adoption of these concurrent reproposed rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for the changes upon adoption, which are effective upon publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

Three public comments were received from an insurance company (Prudential Insurance Company of America), a reinsurance company (Reinsurance Association of America) and an insurance association (American Insurance Association).

COMMENT: One commenter suggested that the qualification in the definition of managing general agent ("MGA") set forth at N.J.A.C. 11:17-6.2, which concerns the authority to adjust or pay claims, be limited to claims in excess of $100,000.

RESPONSE: The Department believes that a $100,000 per claim limit would unduly limit the Commissioner's ability to regulate and monitor MGA's by excluding persons with substantial authority to affect the financial conditon of an insurer.

COMMENT: One commenter objected to N.J.A.C. 11:17-6.3(c) and (d), the surety bond and Errors and Omissions ("E & O") requirements. The commenter objected to the rules provision which prevents the surety bond and E & O coverages from being written by the insurer or affiliate of the insurer contracting with the MGA. The commenter believes that the application of this restriction to an affiliate of the insurer contracting with the MGA is unnecessarily overreaching. The commenter stated that if a coverage is properly written with a sound insurer, it should be acceptable for purposes of satisfying the requirements of this rule and the consumer public will have greater alternatives.

RESPONSE: Bond and E&O coverages of the MGA are necessary to protect the public in the event of the insolvency of the insurer because of the acts of the MGA; they may be of little value if underwritten by the insolvent insurer.

COMMENT: One commenter expressed concern with N.J.A.C. 11:17-6.7(b), which requires the MGA to maintain all books and records of account for a period of five years after the termination of the contract. The commenter believes that this provision will present some problems for insurers. The commenter stated that a company should have access to these records after the termination of the MGA contract. Additionally, the commenter believes that this language may be misinterpreted as somehow empowering the MGA with some authority, other than agreed to by the insurer, for the five years following termination of a contract. (For example, the MGA may continue to collect premiums on a contract that is renewed and then tender them to the insurer for that five-year period following the termination of the contract because it has to maintain the records of account.) The commenter suggested that the Department provide some additional language reflecting the fact that no such authority exists.

RESPONSE: Nothing in this rule affects the insurer's right and obligations to obtain or maintain records, or its ability to provide for such in its agreement with the MGA. The Department's intent is to require the MGA to maintain the books and records of the account. This can be accomplished by requiring the MGA to keep copies of records for

five years after termination of the contract with the insurer, and does not require the insurer to relinquish control of the records. This provision will allow the Department to review the MGA's records (copies) in case of an audit by the Department, but it does not mean that the MGA can continue to collect premiums once the contract with the insurer has been terminated.

COMMENT: Two commenters expressed concern with N.J.A.C. 11:17-6.7(c), which addresses record maintenance requirements. The first commenter objected to the provision for allowing the Commissioner to obtain records directly from the MGA. The commenter stated that since the MGA is an agent for the insurer, it is the insurer which has the ultimate responsibility for the business written by the MGA. The commenter observed that it is necessary that separate records of the business written by the MGA be maintained. The commenter stated that the insurer must have access to the records, the right to copy them, and the records must be in a format usable by the insurer and the Commissioner. The commenter believes that it is the responsibility of the insurer to produce the records for the Commissioner. The commenter recommended that the Department delete N.J.A.C. 11:17-6.7(c), and replace it with Section 4.D of the NAIC Managing General Agents Model Act, which provides:

Separate records of business written by the MGA will be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the Commissioner shall have access to all books, bank accounts and records of the MGA in a form usable to the Commissioner...

The second commenter stated that this provision raises a concern that insurers may be cut out of an opportunity to see documents that may very well need to be seen. The commenter believes that this provision seems to limit access to the records specified therein to a request for production for examination by the Commissioner. The commenter stated that in the event of a termination of an MGA, gaining access to critical records may be a problem. Therefore, the commenter recommended that both sections clearly state an insurer's right to access all records.

RESPONSE: All MGA's must first be licensed as producers; this provision merely restates the current producer record maintenance requirements. MGA's are already bound by the insurance producer's record and maintenance requirements, therefore no undue burden is being placed on them. The Department is just restating what a MGA is required to do.

The Department notes that section 4.D of the NAIC Model Act is essentially codified at P.L. 1993, c.237, section 6d.

COMMENT: One commenter objected to N.J.A.C. 11:17-6.7(c), because the provision fails to require notice to the insurer which is the joint owner of the MGA's records. The commenter asserted that the State's MGA statutory provisions differ from the NAIC model and expressly allow the Commissioner specific access to the MGA's books, bank accounts and records even apart from a general examination of the MGA. However, the commenter believes that since the statute does acknowledge joint ownership by the MGA and the insurer of claim records, that any access to such by the Commissioner should at least require notice to the insurer. Additionally, the commenter believes based on a proprietary and/or confidential nature of other records relating to the insurer's business, notice should be given to the insurer of any records accessed by the Commissioner.

RESPONSE: The Department disagrees with the commenter. The Department believes that since MGA's are licensed producers first, the Commissioner has every right to access this information without being required to notify the insurer. The MGA's contract with the company may require notice to the carrier.

COMMENT: Two commenters objected to N.J.A.C. 11:17-6.7(d)3, which addresses the maintaining of books and records electronically. One commenter stated that the requirement that every 30 days electronic records should be reproduced onto hard copy is an unnecessary burden that can be eliminated if the records are required to be kept in a format usable to the Commissioner. The commenter believes that the adoption of Section 4.D of the model as cited above would put this requirement into the regulation.

A second commenter objected to the provision that requires all electronically maintained records to be translated onto hard copy and stored in that form for five years unless the electronic system can be shown to be unalterable. The commenter believes that it is unlikely that any electronic system is unalterable; therefore, the commenter stated that this is an "empty" exemption. In addition the commenter stated that the hard copy is no less alterable. The commenter believes that the expense of reproduction and storage serves no purpose.

RESPONSE: The record maintenance requirements of these rules are already applicable to MGA's as a result of their status as licensed producers which they should already be complying with; therefore, the Department does not believe that an unusual burden is being placed on MGA's as a result of this requirement, which just restates reasonable requirements already in effect for licensed producers.

Summary of Agency-Initiated Changes:

The Department has amended N.J.A.C. 11:17-6.3(a), the requirements for being an MGA, to state that the MGA's license authority is the same authority they have as a producer. Therefore, a person who has a producer's license with property casualty authority can act as an MGA for property casualty insurers. A person who does not have life/health authority as a producer must satisfy the requirements for being a producer with life/health authority in order to act as an MGA for a life/health company. This clarification is necessary to assume consistency in this subchapter with the Producer Licensing Act, N.J.S.A. 17:22A-1 et seq. and rules, N.J.A.C. 11:17-2.

The Department has made some minor editorial changes to Forms A and B. The Department has deleted one space from the company reference number on Form A. The Department has added one space for the insurance producer reference number.

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

SUBCHAPTER 6. MANAGING GENERAL AGENTS

11:17-6.1 Purpose and scope

This subchapter implements the provisions of P.L.1993, c.237. This subchapter sets forth the procedures for the regulation of certain persons, firms, associations or corporations who act as managing general agents on behalf of insurers.

11:17-6.2 Definitions

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

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

"Insurer" means:

1. Any corporation, association, partnership, reciprocol exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq., or N.J.S.A. 17B:17-1 et seq.;

2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;

5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"Managing general agent" or "MGA" means any person, firm, association or corporation who binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer, including the management of a separate division, department or underwriting office, and acts as an agent for that insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent of the policyholder surplus as reported in the last annual statement of the insurer in any one quarter or year together with one or more of the following:

1. Authority to adjusts or pays claims in excess of $5,000 per claim or in the aggregate, if the claims will settle for $100,000 or more in a year; or

2. Negotiates reinsurance on behalf of the insurer.

Notwithstanding the above; the following persons shall not be MGAs for the purposes of this subchapter:

1. An employee of the insurer;
2. A United States manager of the United States branch of an alien insurer;
3. An underwriting manager which, pursuant to contract, manages all or part of the insurance operations of the insurer, is under common control with the insurer, subject to N.J.S.A. 17:27A-1 et seq., and whose compensation is not solely based on the volume of premiums written;
4. An attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or inter-insurance exchange under powers of attorney.

"Nonresident" means a person who neither resides in New Jersey nor maintains an office in New Jersey where insurance business is transacted.

"Producer" means a person licensed in accordance with N.J.S.A. 17:22A-1 et seq. and N.J.A.C. 11:3-17.

"Resident" (of New Jersey) means a person who either resides in New Jersey or maintains an office in New Jersey where insurance business is transacted.

11:17-6.3 Requirements for MGA

(a) No person, firm, association or corporation shall act in the capacity of a managing general agent with respect to risks located in this State for an insurer licensed in this State unless such person is licensed as an insurance producer in this State***, with authority for the kind or kinds of business to be transacted***.

(b) No person, firm, association or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this State with respect to risks located outside of this State unless such person is licensed as a producer in this State.

(c) All managing general agents shall acquire and maintain a surety bond for the protection of the insurer contracting with the managing general agent. The bond shall be in the amount of $100,000 or 25 percent up to $10,000,000 of the direct premium written by the insurer for the previous calendar year that is attributable to the managing general agent, whichever is greater.

1. The bond amount shall be adjusted accordingly on or before April 1st of each year.
2. The bond shall be executed by an admitted company authorized to transact fidelity and surety business in New Jersey. The bond shall not be written by the insurer or an affiliate of the insurer contracting with the managing general agent.
3. The executed bond shall be submitted to the insurance company contracting with the MGA.

(d) All managing general agents shall acquire and maintain an errors and omissions insurance policy. The policy coverage limits shall be set at $100,000 or 25 percent up to $10,000,000 of the direct premium written by an insurer for the previous calendar year that is attributable to the MGA, whichever is greater.

1. The policy coverage limits shall be adjusted accordingly on or before April 1st of each year.
2. The errors and omissions policy shall be issued by an insurer admitted to do business in New Jersey or an eligible surplus lines insurer. The policy shall not be written by the insurer or an affiliate of the insurer contracting with the MGA.
3. Proof of an errors and omissions insurance policy shall be submitted to the insurance company contracting with the MGA.

(e) The obligations of the MGA to maintain in force a bond and errors and omissions insurance as provided in this section shall continue until Notice of Termination of Managing General Agent Contract is filed with the Department as provided in this subchapter.

11:17-6.4 Insurer requirements

(a) No insurer shall appoint or continue to use the services of any MGA to act for it in this State, either directly or indirectly through sub-agents of the MGA, unless the managing general agent is qualified to act as an MGA in this State pursuant to N.J.A.C. 11:17-6.3.

(b) The insurer shall maintain and make available to the Commissioner upon request a copy of the following:

1. An executed contract between the MGA and the insurer;
2. An executed bond in accordance with N.J.A.C. 11:17-6.3(e); and
3. Proof of the MGA's errors and omissions coverage in accordance with N.J.A.C. 11:17-6.3(d).

(c) Thirty days of entering into, or within 15 days of terminating, a contract with an MGA, the insurer shall provide written notification of the appointment or termination of the MGA to the Commissioner.

1. Notices of appointment of an MGA filed pursuant to N.J.A.C. 11:17-6.5 shall be filed in the form as set forth as Form A in the Appendix to the subchapter and shall include a statement of duties which the MGA is expected to perform on behalf of the insurer, the lines of insurance for which the MGA is to be authorized to act, and any other information the Commissioner may request. Additionally, the insurer shall include a fee in the amount of $20.00.
2. An insurer shall notify the Commissioner of the termination of the MGA relationship by filing a Notice of Termination of Managing General Agent Contract, by certified mail in the form set forth as Form B in the Appendix to this subchapter.

11:17-6.5 Filing requirements

(a) No person, firm, association or corporation shall act as an MGA with respect to risks located in this State for an insurer licensed or domiciled in this State, unless the MGA and the insurer have notified the Commissioner as provided (b) below.

(b) Insurers and MGAs required to notify the Commissioner as provided in (a) above shall file a Notice of Managing General Agent Contract in the form set forth as Form A in the Appendix to this subchapter incorporated herein by reference by completing and jointly executing the form and sending it to the Department at the following address:

Attn: License Processing
New Jersey Department of Insurance
20 West State Street
CN 327
Trenton, NJ 08625

(c) The Commissioner may refuse to file any Notice of Managing General Agent Contract that is incomplete. The Commissioner shall notify the insurer of a determination that the Notice is incomplete, and the actions that must be taken or the items that must be submitted in order to make a complete filing.

11:17-6.6 Claim processing requirements

(a) If the contract between the MGA and the insurer permits the MGA to settle claims on behalf of the insurer the MGA shall comply with the requirements governing the settlement of claims set forth in N.J.S.A. 17:29B-4, 17B:30-13.1 and 17B:30-13.2 as applicable and any regulations promulgated by the Commissioner thereunder. In addition:

1. All claims shall be reported to the company within 30 days of a claim being reported to the MGA, unless otherwise specified with the insurer; and
2. A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

i. Has the potential to exceed $1,000,000 or exceeds the limit set by the insurer, whichever is less;
ii. Involves a coverage dispute;
iii. May exceed the managing general agent's claims settlement authority;
iv. Is open for more than six months; or
v. Is closed by payment of $1,000,000 or an amount set by the insurer, whichever is less.

APPENDIX
FORM A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF MANAGING GENERAL AGENT CONTRACT

To: Commissioner of Insurance, State of New Jersey

From:

|_____|_____|_____|_____|_____|_____|_____|*[_____]* _____

Company Reference No. Name of Company

The following producer gives notice of the establishment of an agency contract between this company and the insurance producer named below:

|_____|_____|_____|_____|_____|_____|_____|*_____|*

Insurance Producer Reference No.

THIS INFORMATION MAY NOT BE OMITTED

_____

PRINT Name of Insurance Producer (Last, First, Middle)

|_____|_____| |_____|_____| |_____|_____|

month day Year

Date of Birth

THIS INFORMATION MAY NOT BE OMMITTED IF AN INDIVIDUAL PRODUCER

as its Managing General Agent in New Jersey commencing |_____|_____| month |_____|_____| day |_____|_____| year for:

Contract Date

all types of insurance for which the company and producer are jointly authorized. The above producer has filed with this company a bond and Errors and Omissions policy in accordance with N.J.A.C. 11:_____

I have determined that the insurance producer named holds a current New Jersey insurance license, authorizing transaction of the kinds of insurance covered by this contract. We understand that the bond and E&O policy must be updated yearly.

_____ |_____|_____| _____

Authorized Company Signature Date Phone Number

_____ _____

Print Name and Title Office Address

_____

Date

_____ _____

Insurance Producer Signature Date

Attach a $20.00 company check made payable to: STATE TREASURER OF NEW JERSEY
DT630/INABROP/m/1

FORM B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF TERMINATION OF MANAGING GENERAL AGENT

To: Commissioner of Insurance, State of New Jersey

From: |___|___|___|___|___|___|___| _____
Company Reference No. Name of Company

The undersigned hereby gives notice of the termination of the agency contract between this company and the insurance producer named below:

|___|___|___|___|___|___|___|*___|*
Insurance Producer Reference No.

THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

Said contract terminated on |___|___| |___|___| |___|___|
month day Year
Termination Date

Reason for Termination: _____

_____

_____

If the reason for termination is agent misconduct, mail an additional copy of this form to: Director of Enforcement, Department of Insurance, CN 325, Trenton, NJ 08625-0325

_____ |___|___| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address

_____
Date

DT630/INABROP/m/2

11:17-6.7 Record maintenance

(a) All policy and claim files shall be the joint property of the insurer and MGA. Upon termination of the MGA appointment for this State, all original policy and claim files shall be returned to the insurer. The MGA may retain copies of these files.

(b) All books and records of account shall be maintained by the managing general agent for a period of five years after the termination of the contract.

(c) All records, books and documents required to be maintained by the managing general agent in accordance with the provisions of this subchapter shall, upon his or her request, be produced for examination by the Commissioner or his or her duly authorized representatives.

(d) The books and records required by this subchapter to be maintained may be maintained electronically if the following conditions are met:

1. That all the elements required by this chapter to be maintained are contained in the electronic system;

2. That, upon the request of the Department, the electronically kept records can be reproduced in hardcopy; and

3. That, at least every 30 days, the records maintained electronically are reproduced in hardcopy and maintained on file for a period of five years after the termination of coverage for an insured, or, alternatively, are maintained for said period of five years on an electronic system that is, in the opinion of the Commissioner, unalterable. Such a determination of unalterability shall be made by the Commissioner, in writing, before any electronic system may be used for storage beyond 30 days.

11:17-6.8 Penalties

(a) If the Commissioner finds, after notice and opportunity for a hearing pursuant to the provisions of the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq. as implemented by the uniform rules of Administrative Procedure, N.J.A.C. 1:1, that any person has violated any provisions of P.L. 1993, c.237 or this subchapter, the Commissioner may refuse to issue or renew the insurance producer's license, or may revoke or suspend the insurance producer's license.

(b) In addition, or as an alternative to any other penalty, the Commissioner may:

1. Impose a fine of up to $5,000 for the first violation, and not exceeding $10,000 for each subsequent violation, and in appropriate circumstances order restitution of moneys owed to any person and reimbursement of the costs of investigation and prosecution.

2. Order the MGA to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of this act committed by the managing general agent.

(c) If the Commissioner finds that the interests of the public require that immediate action be taken prior to completion of the hearing, the making of a determination and the entry of a final order, he may enter an appropriate order to be effective pending completion of the hearing and entry of a final order. These orders may be entered on ex parte proofs if the proofs indicate that the Commissioner's withholding of any action until completion of a full hearing will be harmful to the public interest. Orders issued pursuant to this subsection shall be subject to an application to vacate upon 10 days' notice, and a preliminary hearing on the ex parte order shall be held in any event within 20 days after it is entered. In the alternative, or in addition, the Commissioner is authorized to institute a proceeding in the Superior Court, to be conducted in a summary manner, for an injunction against specified acts or conduct in aid of the proceedings pending before him, including temporary injunctions and interim restraints.

(a)

DIVISION OF LICENSING ENFORCEMENT AND CONSUMER PROTECTION

Reinsurance Intermediaries

Adopted Concurrent New Rules: N.J.A.C. 11:17-7

Proposed: September 7, 1993 at 25 N.J.R. 4323(a).

Adopted: October 15, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: October 15, 1993 as R.1993 d.564, **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. 17:1-8.1, 17:1C-6(e) and P.L.1993, c.244 (enacted August 9, 1993).

Effective Date: October 15, 1993, Readoption of emergency rules; November 15, 1993, Change upon adoption.

Expiration Date: April 15, 1998.

These rules were adopted on an emergency basis and concurrently reproposed on September 7, 1993 pursuant to N.J.S.A. 52:14B-4 (see 25 N.J.R. 4323(a)). The present adoption of these concurrent reproposed new rules is effective upon acceptance for filing at the Office of Administrative Law (see N.J.A.C. 1:30-4.4(d)), except for changes upon adoption, which are effective on the date of publication of this notice, November 15, 1993.

Summary of Public Comments and Agency Responses:

Four public comments were received from insurance companies (Prudential Insurance Company of America and Royal Insurance Company), a reinsurance company (Balis and Company Incorporated) and a reinsurance broker (Bates Turner, Incorporated).

COMMENT: Two commenters objected to N.J.A.C. 11:17-7.3(a), which provides that no person shall act as a reinsurance intermediary in this State unless licensed as a producer in this State. The first commenter believes that this is inconsistent with N.J.A.C. 11:17-7.4(a), which addresses the possibility of a reinsurance intermediary broker being licensed in another state with a substantially similar law.

A second commenter stated that N.J.A.C. 11:17-7.3(a) seems to indicate that a person must be licensed as a producer in New Jersey to operate as a Reinsurance Intermediary. This commenter stated that N.J.A.C. 11:17-7.4(a) indicates that if the person is either a licensed producer in New Jersey or a licensed producer in another state with substantially similar legislation, he may operate as a reinsurance intermediary broker in New Jersey.

The second commenter stated that N.J.A.C. 11:17-7.4(a), with its provision for reciprocity, comports with the spirit of the NAIC Model Act. The commenter stated that he is licensed as a Reinsurance Intermediary-Broker in Texas, which has a law substantially similar to New Jersey, and maintains no office in New Jersey. The commenter questions whether he needs to become licensed in New Jersey.

RESPONSE: The Department disagrees with the first commenter. The Department interprets the phrase to "act as a reinsurance intermediary in this State" to mean one who represents a New Jersey domestic insurer; or who maintains an office in this State for the purpose of conducting the business of a reinsurance intermediary. While the Department recognizes that other persons transacting the business of reinsurance intermediaries may have casual contact with this State, if the person does not represent a New Jersey domestic or does not maintain an office in this State, they are not required to be licensed as a producer in this State, and authorized as a reinsurance intermediary.

A reinsurance intermediary who is licensed in a state with a substantially similar law does not have to become licensed in New Jersey so long as he does not represent a New Jersey domestic insurer or maintain an office in this State. Such persons may have casual contact with this State in the course of their reinsurance intermediary business under the authority of a license issued elsewhere.

COMMENT: One commenter expressed concern with N.J.A.C. 11:17-7.4(c), which refers to the required notification "as provided in (a) above . . ."; however, there is no requirement for notice in N.J.A.C. 11:17-7.4(a). Additionally, this provision provides for the filing of a Notice of Reinsurance Intermediary-Manager by reinsurers and reinsurance intermediaries that are required to notify the Department. The

commenter stated that the required notice should be limited to reinsurance intermediary-managers and the reinsurers that employ them. The commenter believes that if this is not done it will be inconsistent with N.J.A.C. 11:17-7.5(d)2.

RESPONSE: The Department agrees with the commenter and has amended this section, so that reinsurers and their reinsurance intermediary-managers are required to file the Notice of Reinsurance Intermediary-Manager form set forth in Form A of the Appendix.

COMMENT: One commenter is opposed to the adoption of these rules because of the burden placed on him for several months by duplicative and unnecessary licensing procedures adopted by a small minority of states. The commenter stated that most states have adopted the NAIC's Reinsurance Intermediary Act with little or no change. The commenter stated that the NAIC Act does not require licensing in each state if the reinsurance intermediary broker is licensed in a state with substantially similar laws. The commenter noted that he is licensed in New York, Kansas, Texas and Illinois, and that he is not subjected to the duplicative licensing procedures in most cases.

The commenter stated that the Reinsurance Intermediary Act proposed in New Jersey and adopted by a few other states requires licensing despite the fact that reinsurance intermediaries have complied with nearly identical licensing procedures in other states. The commenter believes that the duplication is inefficient and adds no regulatory protection for citizens of New Jersey. The commenter therefore urges New Jersey to adopt a reciprocal licensing provision.

The commenter stated that if a reciprocal licensing provision cannot be adopted, the Department should delete the provisions of the rules which require reinsurance intermediaries to designate an address within the State of New Jersey for receipt of notices. The commenter believes that mail sent to a reinsurance intermediary in their home state is no more costly than mail sent within the State of New Jersey. The commenter believes that such a provision increases administrative expenses and the likelihood of a notice being lost, misplaced or mishandled. The commenter therefore urges the Department to delete any portion of the rules that require reinsurance intermediaries to designate an address within New Jersey for notices.

RESPONSE: The Department permits a person to act pursuant to a reinsurance intermediary license issued in another state as long as that person does not represent a New Jersey domestic insurer or maintains an office in this State. The Department believes that its regulatory interest in these two categories of reinsurance intermediaries require licensure here.

COMMENT: One commenter stated that the Department's rules differ from the NAIC model only in the obvious delineation of the amount of the bond required, $100,000 or 25 percent up to $10,000,000 of the gross amount of direct written premium by reinsurance attributable to the reinsurance intermediary. The commenter believes that this amount appears somewhat high but is not necessarily excessive.

RESPONSE: The Department believes that the amount of the bond required is necessary for the protection of the ceding insurer and the public. The Department does not believe that this amount is excessive.

Summary of Agency-Initiated Changes:

The Department has amended N.J.A.C. 11:17-7.3 to recognize that a reinsurance intermediary's license authority should be the same authority which qualified him or her as a producer. Therefore, a person who has a producer's license with property casualty authority is authorized to act as a reinsurance intermediary with regard to property casualty insurers. A person who does not have life/health authority as a producer but wishes to be a reinsurance intermediary with life/health authority must first satisfy the life/health authority requirements for a producer. This requirement is necessary to conform this subchapter with the provisions of the Insurance Producer Licensing Act, N.J.S.A. 17:22A-1 et seq. and rules, N.J.A.C. 11:17-2.

For clarity, N.J.A.C. 11:17-7.3 is also amended to include a cross reference to N.J.A.C. 11:17-7.4.

The Department has made some minor editorial changes to Forms A, B and C. The Department has deleted one space from the Company reference number on Form A and B. The Department has deleted from Form A the insurance producer's signature and date line because they are not necessary. The Department has also added an additional space for the insurance producer reference number. The Department has amended Form C under Identifying Information to provide space for an individual's date of birth and residence address. On Form C, the Department has also added a notation which notifies persons filing this application that an $8.00 criminal history record information fee is needed for each officer, partner, director and owner of five percent or more who are not on the organization's, corporation's or association's original producer license.

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

SUBCHAPTER 7. REINSURANCE INTERMEDIARIES

11:17-7.1 Purpose and scope

This subchapter implements the provisions of P.L. 1993, c.244. This subchapter sets forth the procedures for the regulation of certain persons, firms, associations or corporations who act as reinsurance intermediaries and for insurers which transact business through a reinsurance intermediary.

11:17-7.2 Definitions

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

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

"Controlling person" means a person which directly or indirectly has the power to direct, or cause to be directed, the management, control or activities of the reinsurance intermediary.

"Insurer" means:

1. A corporation, association, partnership, reciprocal, exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to Subtitle 3 of Title 17 of the Revised Statutes or Subtitle 3 of Title 17B of the New Jersey Statutes;

2. A medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. A hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. A health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.; and

5. A dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.

"Producer" means a person engaged in the business of an insurance agent, insurance broker or insurance consultant pursuant to N.J.S.A. 17:22A-1 et seq.

"Reinsurance intermediary" means a reinsurance intermediary-broker or a reinsurance intermediary-manager.

"Reinsurance intermediary-broker" means a person, other than an officer or employee of the ceding insurer, which solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of that insurer.

"Reinsurance intermediary-manager" means a person which has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer, including the management of a separate division, department or underwriting office, and acts as an agent for that reinsurer whether known as a reinsurance intermediary-manager, manager or other similar term, except that the following persons shall not be considered a reinsurance intermediary-manager, with respect to that reinsurer, for the purposes of this subchapter:

1. An employee of the reinsurer;

2. A United States manager of a United States branch of an alien reinsurer;

3. An underwriting manager which, pursuant to contract, manages all or part of the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to N.J.S.A. 17:27A-1 et seq.; and whose compensation is not solely based on the volume of premiums written;

4. The manager of a group, association, pool or organization of insurers which engages in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner or other similar regulatory officer of the state in which the manager's principal business office is located;

5. A licensed attorney-at-law who negotiates contracts or provides general financial counsel provided no commission or brokerage fee is provided.

"Reinsurer" means any person which engages in the activity of insuring part or all of an insurance risk from an originating or ceding insurer.

11:17-7.3 Requirements for reinsurance intermediaries

(a) No person shall act as a reinsurance intermediary in this State unless licensed as a producer in this State***, with authority for the kind and kinds of business to be transacted***. The Commissioner may authorize a person to act as a reinsurance intermediary if that person has complied with the requirements of this *[subchapter]* ***section and N.J.A.C. 11:17-7.4***.

1. An authorization issued to a firm or association shall authorize all members of the firm or association and any designated employee to act as reinsurance intermediaries under the authorization, and all those persons shall be named in the application and any supplements thereto.

2. An authorization issued to a corporation shall authorize all of the officers, and any designated employee and directors thereof, to act as reinsurance intermediaries on behalf of the corporation, and all those persons shall be named in the application and any supplements thereto.

(b) Any firm, association or corporation licensed as a producer in this State, wishing to be authorized as a reinsurance intermediary shall submit the following:

1. A properly completed application (see Appendix Form C, incorporated herein by reference) requesting authorization to act as a reinsurance intermediary. The application shall be signed, dated and certified to be correct by a licensed officer of the corporation;

i. Applications submitted by a firm or association shall provide in the application the names and New Jersey insurance producer reference numbers of all members of the firm/association and any designated employees, who are licensed as producers to act as reinsurance intermediaries on behalf of the corporation;

ii. Applications submitted by corporations shall provide in the application the names and New Jersey insurance producer reference numbers of all of the officers and any designated employees and directors thereof, who are licensed as producers to act as reinsurance intermediaries on behalf of the corporation;

2. If the applicant seeking authorization as a reinsurance intermediary is a nonresident, the application shall provide that the applicant, as a condition precedent to receiving or holding such authorization, designate the Commissioner as agent for service of process. The applicant shall also:

i. Provide the Commissioner with the name and address of a resident of this State upon whom notices or orders of the Commissioner or process affecting such nonresident reinsurance intermediaries may be served; and

ii. Within 30 days notify the Commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the Commissioner;

3. Any documents or statements required to explain responses to questions concerning the applicant's character, fitness or financial responsibility; and

4. A valid check or money order for $20.00 which shall accompany the application.

(c) A reinsurance intermediary-manager shall acquire and maintain a surety bond for the protection of the reinsurer contracting with the reinsurance intermediary-manager. The bond shall be in the amount of $100,000 or 25 percent up to $10,000,000 of the gross amount of direct premium written by the reinsurer for the previous calendar year that is attributable to the reinsurance intermediary-manager, whichever is greater.

1. The bond amount shall be adjusted accordingly on or before April 1st of each year.

2. The bond shall be executed by an admitted company authorized to transact fidelity and surety business in New Jersey. The bond shall not be written by the insurer or an affiliate of the reinsurer contracting with the reinsurance intermediary.

3. Proof of an executed bond shall be submitted by the insurance company contracting with the reinsurance intermediary and manager.

(d) All reinsurance intermediary-managers shall acquire and maintain an errors and omissions insurance policy. The policy coverage limits shall be set at $100,000 or 25 percent up to $10,000,000 of the direct premium written by a reinsurer for the previous calendar year that is attributable to the reinsurance intermediary-manager, whichever is greater.

1. The policy coverage limits shall be adjusted accordingly on or before April 1st of each year.

2. The errors and omissions policy shall be issued by an insurer admitted to do business in New Jersey or an eligible surplus lines insurer.

3. Proof of an errors and omissions insurance policy shall be submitted to the insurance company contracting with the reinsurance intermediary-manager.

11:17-7.4 Filing requirements

(a) No person, firm, association or corporation shall act as a reinsurance intermediary-broker in this State if the reinsurance intermediary-broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

1. In this State, unless such reinsurance intermediary-broker is a licensed producer in this State; or

2. In another state, unless such reinsurance intermediary-broker is a licensed producer in this State or another state having a law substantially similar to this law or such reinsurance intermediary-broker is licensed in this State as a nonresident reinsurance intermediary.

(b) No person, firm, association or corporation shall act as a reinsurance intermediary-manager:

1. For a reinsurer domiciled in this State, unless such reinsurance intermediary-manager is a licensed producer in this State;

2. In this State, if the reinsurance intermediary-manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this State, unless such reinsurance intermediary-manager is a licensed producer in this State; or

3. In another state for a nondomestic insurer, unless such reinsurance intermediary-manager is a licensed producer in this State or another state having a law substantially similar to this law or such person is licensed in this State as a nonresident reinsurance intermediary.

(c) Reinsurers and ***their*** reinsurance intermediaries***-managers*** *[required to notify the Department as provided in (a) above]* shall file a Notice of Reinsurance Intermediary-Manager in the form set forth as Form A in the Appendix to this subchapter incorporated herein by reference by completing and jointly executing the form and sending the written contract, a valid check or money order for $20.00, and all necessary attachments to the Department at the following address:

Attention: License Processing
New Jersey Department of Insurance
20 West State Street
CN 329
Trenton, New Jersey 08625

11:17-7.5 Insurer requirement

(a) No insurer or reinsurer shall appoint or continue to use the services of a reinsurance intermediary unless the reinsurance intermediary is qualified to act as a reinsurance intermediary in this State pursuant to N.J.A.C. 11:17-7.3 and 7.4.

(b) Transactions between a reinsurance intermediary-manager and the reinsurer it represents in that capacity shall be pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least 30 days before the reinsurer assumes or cedes business through a reinsurance intermediary-manager, a true copy of the approved

contract shall be filed with the Commissioner for approval. The contract shall provide the minimum requirements specified in P.L. 1993, c.244.

(c) Within 15 days of termination of a contract with a reinsurance intermediary-manager, the reinsurer shall provide written notification of that termination to the Commissioner. The reinsurer shall notify the Department of termination of the reinsurance intermediary-manager relationship by filing a Notice of Termination of a reinsurance intermediary-manager the form set forth as Form B in the Appendix to this subchapter. Agency appointment shall not terminate until notice of termination has been received by the Commissioner.

(d) The insurer shall maintain and make available to the Commissioner upon request a copy of the following:

1. For a reinsurance intermediary-manager:

i. An executed bond in accordance with N.J.A.C. 11:17-7.3(c); and

ii. Proof of the reinsurance intermediary-manager's errors and omissions coverage in accordance with N.J.A.C. 11:7-7.3(c); and

2. For a reinsurance intermediary-broker:

i. An executed contract between the reinsurance intermediary-broker and the insurer or reinsurer.

11:7-7.6 Record maintenance

(a) For at least 10 years after the expiration of each contract of reinsurance transacted by the reinsurance intermediary, the reinsurance intermediary shall keep a complete record for each transaction showing:

1. The type of contract, limits, underwriting restrictions, classes or risks and territory;

2. The period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

3. Reporting and settlement requirement of balances;

4. The rate used to compute the reinsurance premium;

5. The names and addresses of assuming reinsurers;

6. The rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary;

7. Related correspondence and memoranda;

8. Proof of placement;

9. Details regarding retrocessions handled by the reinsurance intermediary, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

10. Financial record, including, but not limited to, premium and loss accounts; and

11. When the reinsurance intermediary procures a reinsurance contract on behalf of a ceding licensed insurer.

(b) All records, books and documents required to be maintained by the provisions of this subchapter shall, upon his or her request, be produced for examination by the Commission or his or her duly authorized representatives.

(c) The books and records required by this subchapter to be maintained may be maintained electronically if the following conditions are met:

1. That all the elements required by this subchapter to be maintained are contained in the electronic system;

2. That, upon the request of the Department, the electronically kept records can be reproduced in hardcopy; and

3. That, at least every 30 days, the records maintained electronically are reproduced in hardcopy and maintained on file for a period of five years after the termination of coverage for an insured, or, alternatively, are maintained for said period of five years on an electronic system that is, in the opinion of the Commissioner, unalterable. Such a determination of unalterability shall be made by the Commissioner, in writing, before any electronic system may be used for storage beyond 30 days.

11:17-7.7 Penalties

(a) If the Commissioner finds, after notice and opportunity for a hearing pursuant to the provisions of the Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq. as implemented by the Uniform Rules of Administrative Procedure, N.J.A.C. 1:1, that any person has violated any provisions of P.L.1993, c.244 or this subchapter, the Commissioner may refuse to issue or renew the insurance producer's license, or may revoke or suspend the insurance producer's license.

(b) In addition, or as an alternative to any other penalty, the Commissioner may:

1. Impose a fine of up to $5,000 for the first violation, and not exceeding $10,000 for each subsequent violation, and in appropriate circumstances other restitution of moneys owed to any person and reimbursement of the costs of investigation and prosecution.

2. Order the reinsurance intermediary to reimburse the insurer, the rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer caused by a violation of this act committed by the reinsurance intermediary.

(c) If the Commissioner finds that the interests of the public require that immediate action be taken prior to completion of the hearing, the making of a determination and the entry of a final order, the Commissioner may enter an appropriate order to be effective pending completion of the hearing and entry of a final order. These orders may be entered on ex parte proofs if the proofs indicate that the Commissioner's withholding of any action until completion of a full hearing will be harmful to the public interest. Orders issued pursuant to this subsection shall be subject to an application to vacate upon 10 days' notice, and a preliminary hearing on the ex parte order shall be held in any event within 20 days after it is entered. In the alternative, or in addition, the Commissioner is authorized to institute a proceeding in the Superior Court, to be conducted in a summary manner, for an injunction against specified acts or conduct in aid of the proceedings pending before him or her, including temporary injunctions and interim restraints.

APPENDIX
FORM A

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF REINSURANCE INTERMEDIARY-MANAGER

To: Commissioner of Insurance, State of New Jersey

From: |___|___|___|___|___|___|*[____]* _____
Company Reference No. Name of Company

The following producer gives notice of the establishment of an agency contract between this company and the insurance producer named below:

|___|___|___|___|___|___|*____|*
Insurance Producer Reference No.

THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

|___|___| |___|___| |___|___|
month day Year
Date of Birth

THIS INFORMATION MAY NOT BE OMITTED IF AN INDIVIDUAL PRODUCER

as its Reinsurance Intermediary-Manager Agent in New Jersey commencing |___|___| month |___|___| day |___|___| year for:
Contract Date

all types of insurance for which the company and producer are jointly authorized. The above reinsurance intermediary-manager producer has filed with this company a bond and Errors and Omissions ("E&O") policy in accordance with N.J.A.C. 11:_____

I have determined that the reinsurance intermediary-manager named holds a current New Jersey insurance license, authorizing transaction of the kinds of insurance covered by this contract. We understand that the bond and E&O policy must be updated yearly.

_____ |___|___| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address
1 Reinsurance Intermediary-Manager

_____
Date

[_____] *[_____]*
Insurance Producer Signature Date

Attach a $20.00 company check made payable to: STATE TREASURER OF NEW JERSEY

Attach a copy of the contract between the company and the reinsurance intermediary-manager.

FORM B

STATE OF NEW JERSEY
DEPARTMENT OF INSURANCE
License Processing
CN 327
Trenton, New Jersey 08625-0327

NOTICE OF TERMINATION OF REINSURANCE INTERMEDIARY-MANAGER

To: Commissioner of Insurance, State of New Jersey

From: |__|__|__|__|__|__|__| _____
Company Reference No. Name of Company

The undersigned hereby gives notice of the termination of the agency contract between this company and the insurance producer named below:

|____|____|____|____|____|____|*____|*
Insurance Producer Reference No. THIS INFORMATION MAY NOT BE OMITTED

_____
PRINT Name of Insurance Producer (Last, First, Middle)

Said contract terminated on |___|___| |___|___| |___|___|
month day Year
Termination Date

Reason for Termination: _____

_____

_____

If the reason for termination is agent misconduct, mail an additional copy of this form to: Director of Enforcement, Department of Insurance, CN 325, Trenton, NJ 08625-0325

_____ |___|___| _____
Authorized Company Signature Date Phone Number

_____ _____
Print Name and Title Office Address

_____
Date

DTREG.1/LRWPC

FORM C

NEW JERSEY DEPARTMENT OF INSURANCE
LICENSE PROCESSING
CN-327 - 20 W. STATE STREET
TRENTON, NEW JERSEY 07625-0327

APPLICATION FOR RESIDENT OR NON-RESIDENT
ORGANIZATION CORPORATION/PARTNERSHIP OR INDIVIDUAL
REINSURANCE INTERMEDIARY AUTHORIZATION

A. IDENTIFYING INFORMATION:

[Full legal name of organization or individual licensee]

Full legal name of organization:

_____

_____

Full legal name of the individual licensee:

_____

_____

***Date of Birth:** _____ *

Trade name, if any:

_____

_____

***Residence Address:**

_____

_____

_____ *

N.J. Producer Reference # _____

B. BUSINESS INFORMATION:

Business Address: If your Business Address is located in New Jersey, then you are a Resident Applicant.

Room No. _____ Suite No. _____ Apt. No. _____

_____
Street Address

P.O. Box No. _____ _____

You must supply a street or location address; a P.O. Box alone is not sufficient. The City, State and Zip Code must reflect the location of the P.O. Box.

_____ _____ _____ - _____
City State Zip Code (include +4, if known)

_____
County (If NJ Resident)

Federal ID Number: _____ - _____

Business Telephone Number: _____ - _____ - _____

Telefax Number, if any: _____ - _____ - _____

NON RESIDENTS ATTACH A CERTIFICATION OF CURRENT LICENSE STATUS ISSUED BY INSURANCE LICENSING AUTHORITY IN HOME STATE SHOWING YOU ARE AUTHORIZED IN YOUR HOME STATE AS A REINSURANCE INTERMEDIARY. (IF YOUR HOME STATE DOES NOT AUTHORIZE REINSURANCE INTERMEDIARIES, PLEASE ATTACH A WRITTEN EXPLANATION.)

C. **IDENTIFICATION OF ALL OFFICERS, PARTNERS, DIRECTORS AND OWNERS OF 5% OR MORE OF THE ORGANIZATION, OR EMPLOYEES DESIGNATED TO ACT AS REINSURANCE INTERMEDIARIES.**

(Please Print Cleary or Type)

1. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

2. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

3. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

4. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

5. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

6. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birtn: _____ - _____ - _____

7. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

8. Name _____
LAST, FIRST MI (Example: SMITH, JOHN A)

NJ License Reference #: _____ Date of Birth: _____ - _____ - _____

ATTACH ADDITIONAL SHEETS IF NECESSARY

D. YOU MUST ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE BOX:

1. Have you (or the organization or any officer, partner, director or owner of 5% or more) or designated employee been arrested, indicted or convicted of a crime, misdemeanor or disorderly person offense in this state, other state, or by the federal government since the effective date of your (their) producer license ? ____ Yes ____ No

   If yes, attach a certified copy of the indictment or judgement of conviction, which may be obtained from the clerk of the court of where the conviction was entered.

2. Have you (or the organization or any officer, partner, director or owner of 5% or more) or designated employee had any business or professional license suspended or revoked since the effective date of your (their) producer license? ____ Yes ____ No

   If yes, attach a copy of order of suspension or revocation from professional or governmental authority.

3. Are you (or any officer, partner, director or owner of 5% or more, if an organization) or designated employee indebted (other than accounts current) to any insurance company, producer or insured or has any judgement been rendered against you, since the effective date of your (their) insurance producer license which has not been satisfied or vacated, for money received from or owned to any insurance company, producer or insured? ____ Yes ____ No

   If yes, attach copies of the judgement and other information concerning the nature of and amount of the indebtedness.

E. I/WE HEREBY CERTIFY THAT:

1. I/WE give the New Jersey Department of Insurance permission to verify any information supplied with any federal state or local government agency.

2. All of the information submitted in this application and all attachments is true and complete. I am/We are aware that submitting false information in connection with this application is grounds for revocation of license and may subject me/us to other civil or criminal penalties.

3. As a licensed officer/partner of the organization or as an individual licensed producer, I understand that I am individually and jointly responsible for the insurance related conduct of the organization or my employees.

Must be signed by all individuals identified in section C of the previous page. (Attach additional sheets if necessary.)

Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date
Signature	Date	Signature	Date

G. FEES:

Application Processing Fee $20.00

You must attach a completed history check form and an additional fee of $8.00 should be enclosed for each officer, partner, director and owner of 5% or more who are not on the organization's, corporation's or association's producer license in order for the Department to obtain their Criminal History Record information.

Attach one check or money order for the total fee as calculated above, made payable to "State Treasurer of New Jersey."

(a)

INDIVIDUAL HEALTH COVERAGE PROGRAM

Individual Health Coverage Program Board Temporary Plan of Operation

Adopted New Rules: N.J.A.C. 11:20-2

Proposed: September 13, 1993 in accordance with P.L. 1993, c.164, section 7 (see 25 N.J.R. 4707(a), October 18, 1993).

Adopted: October 14, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance in accordance with P.L. 1993, c.164, section 7.

Filed: October 14, 1993 as R.1993 d.550, **with substantive changes** not requiring additional public notice or comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17:1-8.1, 17:1C-6(e) and 17B:27A-2 et seq. as amended by P.L. 1993, c.164, section 7.

Effective Date: October 14, 1993.

Expiration Date: August 13, 1998.

These new rules were proposed and are being adopted pursuant to the procedures set forth at P.L. 1993, c.164, section 7, as therein authorized.

Accordingly, notice of the proposal of these new rules was sent for publication in three newspapers of general circulation in New Jersey, mailed to all known interested parties, and submitted to the Office of Administrative Law (OAL) for publication in the New Jersey Register.

Pursuant to P.L. 1993, c.164, section 7d, interested parties were provided a comment period of at least 15 days. As set forth in the notice of proposed new rules, the written comment period ended on October 4, 1993.

Pursuant to P.L. 1993, c.164, section 7e, notwithstanding the receipt of comments, the Commissioner of Insurance (Commissioner) may adopt these rules immediately upon the expiration of the public comment period by filing a copy of the adopted rules with the OAL for publication in the New Jersey Register. These new rules are effective upon the date of filing with the OAL, October 14, 1993.

Pursuant to the requirements of P.L. 1993, c.164, section 7, this notice also includes a report listing all parties who provided comments, summarizing the content of the comments, and providing the Department of Insurance's (Department) response to the data, views and arguments contained in the comments.

The only comment received by the Department was from the Department of the Public Advocate.

COMMENT: The commenter noted that N.J.A.C. 11:20-2.5(a)4 provides that a carrier elected to the Individual Health Coverage Program (IHC Program) Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier, and may name one or more alternates. The commenter believes that there is no statutory authority to authorize the naming of alternates as provided in the rule. In addition, the commenter stated that the rule limits the ability to choose alternates to members of the Board which are carriers. The commenter stated that this provision could change the statutorily established balance between different public and private interests currently reflected in the makeup of the Board. The commenter further stated that the impact of the rule could adversely affect consumer interests, in that the rule could exclude the two consumer representatives from absentee participation, while carriers, "who can draw from an inexhaustible organizational supply," would be able to cast their votes at every meeting on every issue. The commenter also believes that there is no basis in law or policy to support this provision, which is apparently designed to afford Board members representing carriers special rights. The commenter stated that it would be inappropriate, and inconsistent with due process rights to be fully heard, to permit an alternate with little knowledge of underlying issues and little or no participation in prior discussions of the Board to vote for a carrier's interest without being required to hear competing points of view.

RESPONSE: The commenter has apparently misconstrued this provision. The provision merely recognizes that a carrier representative is not a natural person, as is an appointed Director, and therefore must select a person from its organization authorized to vote on its behalf. The provision is intended to ensure that the person representing a carrier on the Board has been duly authorized by that carrier to vote on its behalf. The statute contains no restriction or requirement that the individual authorized by the carrier never be changed, as the commenter apparently implies. The Department does not believe that the provision shifts the balance of the makeup of the Board from that which is statutorily mandated since each carrier representative is still afforded only one vote.

COMMENT: The commenter expressed concern with the provisions in N.J.A.C. 11:20-2.5(e), which provides that Directors may vote at meetings by written proxy. The commenter stated that the purpose of the provision is not clear and that the rule departs from "normal" procedures by authorizing a Director not in attendance to cast a proxy vote on any particular resolution or action to be considered by the Board. The commenter believes that this may encourage "non-attendance" by Board members.

In addition, the commenter stated that the rule could encourage Board members to make up their minds on issues beforehand, before they are fully discussed and debated at open Board meetings, before the time of the actual vote, and before Board members ask questions of fellow Directors and engage in debate which is an essential ingredient of decision making by public boards. The commenter also stated that the provision appears to be inconsistent with the strong public policy favoring public debate as evidenced by the Open Public Meetings Act, N.J.S.A. 10:4-6. The commenter concluded that absent specific authorization to the contrary, the provision authorizing written proxy votes is inappropriate.

RESPONSE: In proposing the rules, the Department believed that this provision was reasonable and equitable to carry out the provisions of the statute. The Department notes that the provision for voting by proxy was limited only to a vote on a particular resolution or action before the Board known to the Director prior to the meeting.

Nevertheless, upon careful review of the commenter's concerns and upon advice from the Office of the Attorney General that voting by proxy in this instance is not in keeping with the intent of the Open Public Meetings Act, this provision has been deleted upon adoption.

COMMENT: The commenter stated that the basis of the Board's authority to establish a means test for standard health benefits plans issued pursuant to the statute as provided in N.J.A.C. 11:2-2.3(b)7 is not clear. The commenter stated that the statutory citation set forth in the rule does not address this issue.

RESPONSE: This provision reflects the statutory provision set forth in N.J.S.A. 17B:27A-11g, which provides that the Board shall have a specific authority to "establish, at the Board's discretion, standards for the application of a means test for individual health benefits plans issued pursuant to [N.J.S.A. 17B:27A-4]".

COMMENT: The commenter expressed concern with N.J.A.C. 11:20-2.6(a). The commenter stated that the rule appears to limit non-Director participation on Board committees to carrier members. Accordingly, the commenter believes that the rule encourages over-representation of carriers on such committees since the pool of potential carrier members is unlimited, contrasted with the appointed Directors who number four and whose availability for service on Board committees would be limited by other non-Board activities. The commenter believes that this provision will destabilize the balance of public and private interests represented on the Board. The commenter believes that to avoid this result, the Board would be required to limit the workings of committees to an essential few, which could hamper the Board's accomplishment of its work. The commenter thus requested reconsideration of the rule to maintain balanced viewpoints on the Board's committees.

RESPONSE: This provision reflects the statutory provision at N.J.S.A. 17B:27A-11k, which provides that the Board has authority to appoint from among its members appropriate committees as necessary to provide technical and other assistance in the operation of the IHC Program. The Department has interpreted this provision to permit appointment to committees of both Board members and IHC Program members. There is no statutory provision for appointment to committees by persons who have not been appointed to the Board or otherwise not IHC Program members. The Department notes that the commenter cites no statutory authority by which such appointments could be made, and further that committees are not authorized to act on behalf of the Board but only to make recommendations to the Board.

COMMENT: The commenter expressed concern with N.J.A.C. 11:20-2.6(d)6vi(4), which provides that the Complaint Committee or Interim Administrator or subsequently appointed Administrator may

compile statistics on complaints, disputes and appeals received and resolved. The commenter suggested that the provision be changed to require the Committee to compile these statistics.

RESPONSE: Initially, the Department notes that there is no statutory provision directing the Board to compile such statistics. The Department further notes that these rules establish the Temporary Plan of Operation for the IHC Program to provide for the fair, reasonable, and equitable administration of the IHC Program while the Board continues to work on developing the permanent Plan of Operation. The Department believes that this provision is reasonable for purposes of the Temporary Plan. If the Department required the Complaint Committee to compile the statistics, the Department would also be required to establish the specific data to be maintained. The Department did not believe it necessary to establish such requirements for purposes of the Temporary Plan. Accordingly, the rules encourage the Complaint Committee and Interim Administrator or Administrator to compile statistics. The Department will, however, forward the commenter's suggestion to the IHC Program Board for their consideration in the development of the permanent Plan of Operation.

COMMENT: The commenter specifically expressed support for the compensation of appointed Directors as provided in N.J.A.C. 11:20-2.5(h). The commenter believes that this provision is necessary to help ensure the continued participation of appointed Directors.

RESPONSE: The Department notes the commenter's support for this provision. However, as noted below under the Summary of Agency-Initiated Changes, Counsel has advised that there is no authorization in the statute for the payment of per diem compensation to Directors and, therefore, the Department has revised this rule to delete the provision for compensation for appointed Directors.

COMMENT: The commenter expressed concern with the language in N.J.A.C. 11:20-2.10(a)1, which provides that in designing standard health benefits plans, the Board shall give due consideration to the types of coverage currently in force and/or available in the marketplace, individuals' preferences, and the evolution of the marketplace towards managed care. The commenter believes that the use of the term "managed care" in this context is problematical for several reasons. First, the commenter stated that the term "managed care" is not defined. The term may be used to mean different things, including care delivered through health maintenance organizations (HMOs), or methods of managing care such as pre-certification, mandatory second opinions and utilization review. The commenter stated that if the term managed care is intended to mean HMOs, it believes that it is inappropriate to assume that HMOs would be the means of providing health coverage in New Jersey. The commenter noted that the delivery of health care coverage in New Jersey presently includes indemnity insurance, and that many citizens choose that method over HMOs. The commenter thus believes that their interest should be given equal consideration by Board members.

RESPONSE: The commenter has apparently misconstrued this provision. Initially, the Department notes that the term "managed care" has been used extensively and has been reported in the television and print media in the discussion of the ongoing Federal initiatives regarding health insurance. The Department recognizes that this term is not defined, and notes that it has not been defined at the Federal level. Moreover, the Department recognizes that many individuals choose "traditional" coverage as opposed to HMOs. The rule recognizes this fact, and requires that the Board, in designing such plan, give due consideration to: (1) types of coverages currently available in the market; (2) those coverages reflecting individuals' preferences; and (3) the evolution of the marketplace due to Federal initiatives. The Department believes that this is reasonable so that the Board's benefit plans are developed consistent with any Federal initiatives, perhaps avoiding dramatic revisions to existing plans that may disrupt the market. Finally, the Department notes that pursuant to P.L. 1993, c.164, section 7c, the Board is required to hold a public hearing on the establishment and modification of health benefits plans. Accordingly, all interested parties may participate in the establishment of such plans.

Summary of Agency-Initiated Changes:

Based upon advice from the Office of the Attorney General, N.J.A.C. 11:20-2.5(h) has been revised to delete provision for compensation for appointed directors of up to $150.00 per day for attendance at Board and Committee meetings. There is no express provision authorizing compensation, as is the case when compensation of such Board members is permitted, nor indication from the Legislative history or other provisions of the Act that per diem compensation was intended by the Legislature.

Additionally, the adopted rules contain minor editorial changes from the original notice of proposed new rules previously distributed to conform with OAL codification rules. These changes are already included in the notice of proposed new rules as published in the New Jersey Register.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 2. INDIVIDUAL HEALTH COVERAGE PROGRAM TEMPORARY PLAN OF OPERATION

11:20-2.1 Purpose and structure

(a) The "IHC Program," created pursuant to the N.J.S.A. 17B:27A-2 to 16, amended by P.L. 1993, c.164, has as its members all insurance companies, health service corporations and health maintenance organizations that issue or have in force health benefits plans in this State. The IHC Program's purpose is:

1. To assure the availability of standardized individual health benefits plans in New Jersey on an open enrollment, community-rated basis; and

2. To reimburse certain losses of member companies for the calendar year ending December 31, 1992 pursuant to N.J.S.A. 17B:27A-13 and for calendar years ending December 31, 1993 and thereafter pursuant to N.J.S.A. 17B:27A-12.

(b) The Board of the IHC Program has been charged pursuant to the Act to administer the IHC Program reasonably and equitably under law.

(c) The IHC Program Temporary Plan of Operation sets forth as completely as possible the fair, reasonable and equitable manner in which the Board will administer the IHC Program under law. The Commissioner has adopted the Temporary Plan of Operation pursuant to N.J.S.A. 17B:27A-10e as amended by P.L. 1993, c.164, section 5 and the Temporary Plan will continue in effect until amended or rescinded by the Commissioner.

(d) The Board shall consist of nine directors, including the Commissioner or his or her designee, who shall serve ex officio.

(e) The Board shall appoint an insurance producer licensed to sell health insurance pursuant to N.J.S.A. 17:22A-1 et seq. to advise the Board on issues related to sales of individual health benefits plans issued pursuant to the Act.

(f) Neither the Temporary Plan of Operation nor the IHC Program creates any contractual or other rights and obligations between the IHC Program and any entity or other person insured by any carrier.

(g) The IHC Program shall continue in existence subject to termination in accordance with the laws of this State or of the United States. In the event of enactment of a law or laws which, in the determination of the Board and the Commissioner, shall result in the termination of the IHC Program, the IHC Program shall terminate and conclude its affairs. Any funds or assets held by the IHC Program following the payment of all claims and expenses of the IHC Program shall be distributed to the member carriers at that time and in accordance with the then existing assessment formula.

(h) All documents or other communications directed to the Board shall be sent the Interim Administrator of the IHC Program at the following address:

The Individual Health Coverage Program Board
c/o Interim Administrator
The Prudential Insurance Company of America
P.O. Box 4080
Iselin, NJ 08830

11:20-2.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-2 as amended by P.L. 1993, c.164, and N.J.A.C. 11:20-1, when used in this

subchapter, shall have the meanings as defined therein, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

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

"Action" means an action by the Board adopted, in the Board's discretion, in accordance with the procedures set forth either in the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq., or in sections 7 and 8 of P.L. 1993, c.164. "Action" includes, but is not limited to: the establishment and modification of health benefits plans; procedures and standards for assessment of members and the apportionment thereof, policy form filings, rate fillings, evaluation of material submitted by carriers with respect to loss ratios, and establishment of refunds to policyholders or contract holders; and the promulgation or modification of policy forms. "Action" shall not include the hearing and resolution of contested cases, personnel matters or applications for exemptions.

"Basic health benefits plan" means the health benefits plan designed by the Board in accordance with N.J.S.A. 17B:27A-4c as amended by P.L. 1993, c.164, section 3.

"Deferral" means a deferment, in whole or in part, of payment by a member of any assessment issued by the IHC Program Board, granted by the Commissioner pursuant to N.J.S.A. 17B:27A-12a(3) and N.J.A.C. 11:20-11.

"Director" means a Director of the Individual Health Coverage Program who:

1. Has been elected by the members of the Individual Health Coverage Program and approved by the Commissioner;

2. Has been appointed by the Governor and confirmed by the Senate; or

3. Sits ex officio on the Board of Directors, as applicable, in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c. 164, section 5.

"Financially impaired" means a carrier which, after the effective date of the Act, is not insolvent, but is deemed by the Commissioner to be potentially unable to fulfill its contractual obligations; or a carrier which is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

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

"Plan" means the plan of operation of the IHC Program.

"Reasonable administrative expenses" means actual expenses, including commissions, or a maximum of 25 percent of premium (including commissions), whichever amount is less.

"Standard health benefits plan" means a health benefits plan, including the basic health benefits plan, adopted by the IHC Program board.

"Temporary Plan" means the temporary plan of operation for the IHC Program adopted by the Commissioner in accordance with N.J.S.A. 17B:27A-10 as amended by P.L. 1993, c.164, section 5.

11:20-2.3 Powers of the IHC Program and Board

(a) The IHC Program shall have the general powers and authority granted under the laws of this State to insurance companies, health service corporations and health maintenance organizations licensed or approved to transact business in this State, except that the IHC Program shall not have the power to issue health benefits plans directly to either groups or individuals.

(b) The Board shall have the power to do the following:

1. Define the provisions of standard health benefits plans in accordance with the requirements of the Act and this Temporary Plan;

2. Establish benefit levels, including any optional deductibles and copayments, and exclusions and limitations for standard health benefits plans in accordance with law;

3. Establish standard policy forms for standard health benefits plans and rider packages;

4. Establish a procedure for the joint distribution of information on standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;

5. Establish reasonable guidelines for the purchase of new individual health benefits plans by persons who are already enrolled or insured by another individual health benefits plan;

6. Review rate applications and form filings submitted by carriers in accordance with the Act and this Temporary Plan;

7. Establish standards for a means test for standard health benefits plans issued pursuant to N.J.S.A. 17B:27A-4 as amended by P.L. 1993, c.164, section 3;

8. Promulgate, in conjunction with the New Jersey Small Employer Health Benefits Program, a standard claim form for the standard health benefits policies;

9. Establish minimum requirements for performance standards for carriers that are reimbursed for losses submitted to the IHC Program and provide for performance audits;

10. Make application on behalf of member carriers for benefits, subsidies, discounts or funds that may be provided either by any health care provider or under State or Federal law or regulation;

11. Appoint from among its members appropriate legal, actuarial and other committees necessary to provide technical and other assistance in the operation of the IHC Program, in policy and other contract design and any other functions within the authority of the Board;

12. Enter into contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Temporary Plan;

13. Employ or retain such persons, firms or corporations to perform such administrative functions as are necessary for the Board's performance of its duties;

14. Provide procedures for receiving oral and written comments from the public, which may include rules relating to the time and place of any public hearing, and for the length and format of testimony from individuals, groups and organizations;

15. Establish rules, conditions and procedures pertaining to the sharing of IHC Program losses and administrative expenses among the members of the IHC Program;

16. Calculate assessments and assess member carriers their proportionate share of IHC Program losses and administrative expenses in accordance with N.J.S.A. 17B:27A-12 and this Plan, and make advance interim assessments, as may be reasonable and necessary for organizational and reasonable operating expenses and estimated losses;

i. An interim assessment shall be credited as an offset against any regular assessment due following the close of the fiscal year;

ii. The Board may provide for other credits against assessments as appropriate;

17. Establish and maintain the appropriate accounts necessary to administer the IHC Program;

18. Impose interest penalties upon members for late payment of assessments;

19. Recommend to the Commissioner that actions be instituted in accordance with the Commissioner's authority to impose penalties for violations of the Act;

20. Sue or be sued, including taking any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member carrier;

21. Pursuant to P.L. 1993, c.164, adopt "actions" necessary to execute the Board's powers pursuant to the provisions of N.J.S.A. 17B:27A-2 through 16;

22. Borrow money to effect the purposes of the IHC Program;

i. Any notes or other evidence of indebtedness of the Program not in default shall be legal investments for carriers and may be carried as admitted assets; and

23. Contract for an independent actuary and any other professional services the Board deems necessary to carry out its duties under N.J.S.A. 17B:27A-2 et seq. as amended.

11:20-2.4 Temporary Plan of Operation

(a) The Temporary Plan shall become effective upon adoption by the Commissioner and submission of final action to OAL for publication. The Commissioner may amend the Temporary Plan by providing written notice to the Board of amendments and their effective dates and upon adoption of amendments in accordance with applicable law.

(b) Upon the submission of a Plan by the Board and approval of the Plan by the Commissioner pursuant to N.J.S.A. 17B:27A-10(d) and (e) as amended by P.L. 1993, c.164, section 6, the Commissioner shall amend or rescind the Temporary Plan.

11:20-2.5 Board of Directors

(a) The Board shall consist of nine Directors, including the Commissioner or his or her designee, who shall sit ex officio.

1. Four Directors shall be appointed by the Governor, with the advice and consent of the Senate.

i. One of the Governor's appointees shall be a representative of an employer, appointed upon the recommendation of a business trade association, who has experience in the management or administration of an employee health benefits plan. One of the Governor's appointees shall be a representative of organized labor, appointed upon the recommendation of the AFL-CIO, who has experience in the management or administration of an employee health plan. Two of the Governor's appointees shall be consumers of a health benefits plan who are reflective of the populaton in the State.

ii. The term of the initial appointment shall be for the period as set forth in the appointment.

2. Four Directors shall represent carriers and shall be elected by the members subject to the approval of the Commissioner.

i. To the extent a Carrier elected by the members is willing to serve on the Board, a representative of each of the following types of carrier shall be elected:

(1) A health service corporation;

(2) A health maintenance organization;

(3) A mutual insurer of this State subject to Subtitle 3 of Title 17B of the New Jersey Statutes; and

(4) A foreign health insurance company authorized to do business in this State.

ii. The initial term of Directors representing carriers shall be determined by vote of the members of the IHC Program.

iii. The Board shall hold a meeting, at least annually, of the members of the IHC Program for the purpose of electing Directors to fill any vacancies among the Directors who represent carriers which exist or which will exist within 10 business days following the date of the election meeting pursuant to a resolution of the Board or the expiration of a Director's normal term of office.

(1) On or about 60 days prior to the date of the election meeting, the Board shall send written notice to the IHC Program members setting forth the time, date and place of the election meeting, stating the positions for which a vote is to be taken, soliciting written nominations of candidates for those positions, and stating the last date that written nominations shall be accepted, which shall be no less than 10 business days following the date of the written notice.

(2) Following the close of the nomination period, the Board shall determine from among the carriers nominated those carriers that are eligible and willing to serve in the position for which nominated.

(3) At least 30 calendar days prior to the date of the election meeting, the Board shall send a written notice to members setting forth the candidates to be considered for purposes of voting at the election meeting, along with a ballot by which the member carrier may vote absentee on or before a date specified by the Board, which shall be no earlier than three business days prior to the date of the election meeting.

(4) Affiliated carriers shall have no more than one vote for each position subject to vote.

(5) Elections shall be by a simple majority of those ballots properly cast in person and absentee.

(6) The Board shall maintain a written record of each election, including copies of all notices sent, ballots received and the tally sheets in accordance with its record retention procedures set forth at N.J.A.C. 11:20-2.9.

iv. Prior to the Board's annual meeting set forth at (c) below, or no later than 30 calendar days subsequent to the date of the election meeting, whichever date is later, the Board shall send a written notice to IHC Program members of the names of the Directors of the Board, their respective designees, if any, and the means by which Directors may be contacted during normal business hours by IHC Program members.

3. The Commissioner shall file with the Board a letter naming his or her designee, if any.

4. A carrier elected to the Board shall file with the Board a letter naming the person authorized to vote on behalf of the carrier and may name one or more alternates.

5. Appointed Directors shall promptly notify the Board of any change in circumstance that may affect the representative capacity in which they were appointed. Upon receipt of such notice, the Board shall notify the Governor of the appointed Director's change in circumstance.

6. The Directors representing carriers on the Board shall promptly notify the Board of any change in circumstance that may affect the representative capacity of the entity elected by the members. Upon receipt of such notice, the Board shall provide notice of the same to the members of the IHC Program.

7. Directors shall serve their terms of office until their replacements are duly appointed or elected, as appropriate.

(b) The Board shall elect a Chair and Secretary from among its Directors, and may elect other officers it deems appropriate. As authorized by the Board, such officers may act as signatories on behalf of the Board and perform other ministerial functions necessary and proper to effectuate the actions of the Board.

(c) The Board shall hold an annual meeting at which it shall:

1. Elect officers of the Board;

2. Adopt a schedule of regular meetings for the year;

3. Appoint Directors and other persons to committees of the Board;

4. Ratify the budget; and

5. Take action on such other matters that it deems appropriate.

(d) A majority of the Directors shall constitute a quorum for the transaction of business.

1. Each Director shall have one vote. The acts of a majority of the Directors present at a meeting at which a quorum is present shall be the acts of the Board, except as provided in (d)2 below.

2. The affirmative votes of five Directors shall be required to act upon the following:

i. Amendments to the Plan of Operation;

ii. Amendments to the standard health benefits plans;

iii. Adoption of any actions, as defined by P.L. 1993, c.164, sections 7 and 8, or amendments to the actions of the IHC Program;

iv. Removal of any Director from membership on any committee;

v. Recommendations by the Board to the Legislature regarding amendments to the Act; and

vi. An assessment or interim assessment.

[(e) Directors may vote at meetings by written proxy delivered to the Secretary of Board and stating their vote on any particular resolution or action before the Board known to the Director prior to the meeting.]

*[(f)]***(e)*** All meetings of the Board, including special meetings, shall be subject to the provisions of the Open Public Meetings Act, N.J.S.A. 10:4-6 to 21.

*[(g)]***(f)*** In addition to the annual meeting and any regularly scheduled meeting, the Board may hold special meetings upon the request of the Chair or of three or more Directors.

[(h) Appointed] ***(g)*** Directors shall ***not*** receive compensation for attendance at Board and Committee meetings *[of $150.00 per meeting, not to exceed $150.00 per day]*. Directors may be reimbursed for reasonable unreimbursed travel expenses incurred in attending Board and Committee meetings using the State Travel Regulations issued by the Department of the Treasury as a guide.

*[(i)]***(h)*** The Board shall hold meetings either in person or by teleconference.

*[(j)]***(i)*** The Board shall provide for the taking of written minutes of each Board meeting, including teleconferences and closed sessions, and distribute a copy of the minutes to the Directors and two copies to the Commissioner. The Board shall retain the original of the minutes.

1. The Secretary shall take and maintain the written minutes of the proceedings of the Board meetings, including teleconferences and closed sessions. Board meeting minutes shall set forth as a minimum the following:

i. The time, date and place of the meeting;
ii. The names of all persons attending the meeting, the organizations they represent, if any, and the identity of the person presiding;
iii. A narrative describing what occurred at the meeting including subjects considered and actions taken;
iv. The recorded votes of each member on each matter including abstentions;
v. The complete text of any resolutions adopted by the Board;
vi. As attachments, the agenda for the meeting and accompanying materials; and
vii. Any other information required to be shown in the minutes by law.

11:20-2.6 Committees

(a) The Board shall make appointments to standing and other committees from among Directors and IHC Program members. Each of the standing committees shall include no more than four Directors, but the Chair may appoint additional Directors as needed subject to ratification by the Board at the next subsequent meeting.

(b) The Board may, by resolution:

1. Determine the size of a standing committee, appoint Directors, and fill a vacancy;
2. Appoint a Director to serve as an alternate member of any standing committee to act in the absence of a committee member with all the powers of such absent member;
3. Abolish any standing committee;
4. Remove any person, other than a Director, from any standing commitee at any time, with or without cause; and
5. Appoint or authorize the use of IHC Program staff, consultants, or other advisors to work with any standing committee.

(c) Committees may not take final action; however, within the scope of their purpose and duties, committees may make recommendations and reports to the Board for decision.

(d) Standing committees shall include the following:

1. A Technical Advisory Committee, which shall make recommendations to the Board with respect to:
i. Methods for calculating assessments;
ii. Standards for information requested for rate filings and for review of such rate filings;
iii. Standards of review of loss ratios and incurred losses;
iv. A uniform Audit Program to be utilized by independent auditors retained by carriers in their review of items related to assessments for each affected carrier;
v. Performance standards for carriers that are reimbursed for losses submitted to the IHC Program, and for performance audits that may be conducted from time to time;
vi. Conditional and final exemptions from assessments;
vii. Whether acts of members are not in compliance with the Act and any rules promulgated thereunder;
viii. Reviews of informational rate filings submitted to the Board pursuant to N.J.A.C. 11:20-6;
ix. Whether an informational rate filing is complete;
x. Reviews of loss ratio reports submitted to the Board pursuant to N.J.A.C. 11:20-7;
xi. A member carrier's plan for refunds to policy and contract holders, if necessary;
xii. Any other reports or recommendations to the Board as may be appropriate regarding rates, rate filings and loss ratio reports; and
xiii. Reviews of assertions of non-member status.

2. A Legal Committee, which shall make reports to recommendations to the Board with respect to:
i. Rules to be promulgated by the Board pursuant to the Act;
ii. Amendments to the Plan of Operation and the various individual health benefits plans proposed by the Board;
iii. Any proposed amendments to the Act;
iv. Contracts and legal documents for the IHC Program;
v. All litigation and other disputes involving the IHC Program and its operations;
vi. Coordination with the Office of the Attorney General on matters relating to IHC Program operations; and
vii. Any legal actions necessary or proper for recovery of an assessment for, on behalf of, or against the IHC Program or a member.

3. A Marketing and Communications Committee, which shall make recommendations to the Board with respect to:
i. Rules for implementation and administration of the Act and standards to provide for the fair marketing and broad availability of individual health benefits plans to eligible persons;
ii. Marketing and communication plans for the IHC Program, as needed;
iii. Rules to determine "good faith" marketing efforts by members applying for exemptions;
iv. The insurance producer to be appointed by the Board pursuant to N.J.S.A. 17B:27A-10g, and assist in liaison efforts between the Board and the appointed producer; and
v. A buyers' guide to be distributed to consumers which describes the individual health benefits plans available to eligible persons pursuant to the Act.

4. A Forms Committee, which shall make recommendations to the Board with respect to:
i. Reviews of policy forms submitted to the Board pursuant to N.J.A.C. 11:20-3.2 and application forms submitted to the Board pursuant to N.J.A.C. 11:20-4;
ii. The disapproval of any policy form or application form that is not in substantial compliance with the Act and the Board's rules;
iii. Changes to the Board's standard policy forms, application form and claim form and develop new forms as may be necessary from time to time; and
iv. Whether acts of members are in compliance with the Act and any rules promulgated thereunder.

5. An Operations Committee, which shall make recommendations to the Board with respect to:
i. The engagement of independent financial consultants, including, but not limited to, examiners, auditors, accountants and actuaries;
ii. The Plan of Operation and amendments thereto;
iii. Standards of acceptability for the selection of auditing firms;
iv. The review of reports prepared by independent auditors and other audit-related matters the Board deems necessary; and
v. Contracts which are necessary or proper to carry out the provisions and purposes of the Act and this Plan.

6. A Complaint Committee, which shall make recommendations to the Board with respect to:
i. Consumer, policyholder and member carrier inquiries, complaints and disputes arising in connection with the IHC Program;
ii. The manner by which the Board may address inquiries, complaints and disputes brought to its attention;
iii. Procedures for receiving, logging and handling inquiries, complaints and disputes;
iv. The design of inquiry, complaint and dispute forms;
v. Procedures for making inquiries and complaints and for carriers to use in notifying the Board of complaints and disputes; and
vi. Whether and how to respond to interpretations of the Board's rules made by member carriers and inquiries and complaints received from consumers, policyholders, member carriers or others.

(1) Recommendations by the Complaint Committee may include requesting that the Board issue a statement interpreting its regulations, seek declaratory or injunctive relief as may be appropriate, or other administrative or legal remedies as may be available.

(2) In an effort to answer any inquiry or resolve any dispute or complaint, the Complaint Committee or Interim Administrator or subsequently appointed Administrator may seek the input of another appropriate Committee in order to assist the Complaint Committee in reaching a recommendation.

(3) The Complaint Committee may refer matters as necessary to any other Committee which may also make recommendations to the Board.

(4) The Complaint Committee or Interim Administrator or subsequently appointed Administrator may compile statistics on complaints, disputes and appeals received and resolved and submit an

annual report to the Board and the Commissioner detailing the volume of complaints, disputes and appeals categorized by type, carrier and disposition.

(5) Nothing contained in this paragraph shall be deemed to impair or otherwise affect the authority of the Commissioner to investigate and resolve any complaint or dispute or to take any regulatory or enforcement action with respect to any violations of any State insurance statutes or rules which come to the Commissioner's attention.

(e) The Board may by resolution establish and appoint other committees.

11:20-2.7 Financial administration

(a) The fiscal year of the IHC Program shall run from July 1 to June 30 of each year.

(b) All funds of the IHC Program shall be deposited and disbursements made from the General Treasury in accordance with procedures established and approved by the Department of Treasury, Office of Management and Budget.

1. Monies pertaining to the IHC Program shall be deposited into a dedicated account within the State's General Fund.

2. Monies may be credited from the General Fund to IHC bank accounts upon request by the Board through the Department, which request shall include justification for the request with supporting documentation, and shall be pursuant to the approval of the Director of the Division of Budget and Accounting.

(c) Bank checking accounts shall be established separately in the name of the IHC Program and shall be approved by the Board.

1. The Board shall authorize individuals to sign checks on behalf of the Board.

2. All cash and other assets shall be invested in accordance with the investment policy developed and approved by the Board as permitted by applicable law. All investment income earned shall be credited to the IHC Program and shall be applied to reduce future assessments of members for IHC Program losses and administrative expenses, except as provided in N.J.A.C. 11:20-2.11(g) and 2.12(h).

(d) No disbursements shall be made from IHC bank accounts without the approval of the Board, except that the Board may authorize the Interim Administrator or subsequently appointed Administrator to make disbursements of less than $1,000 per disbursement for administrative purposes subject to such conditions as the Board may prescribe.

(e) All financial records shall be kept in accordance with the State's prescribed policies and procedures. The Board shall maintain the books and records of the IHC Program at a location in New Jersey in a manner so that financial statements may be prepared to satisfy the Act and other requirements of New Jersey law.

1. The receipt and disbursement of cash for the IHC Program shall be recorded as it occurs.

2. Non-cash transactions shall be recorded when assets or liabilities should be realized by the IHC Program in accordance with generally accepted accounting principles.

3. Assets and liabilities of the IHC Program, other than cash, shall be accounted for and described in itemized records.

4. The net balance due to or from the IHC Program shall be calculated for each carrier either when deemed appropriate by the Board or when requested by the carrier. The Board shall maintain records of each carrier's financial transactions with the IHC Program as necessary to ensure compliance with the Act and this Temporary Plan, which records shall include at least the following:

i. Net losses of the IHC Program based upon the assessments calculated in accordance with this Plan;

ii. Any adjustments as set forth in this Plan;

iii. Adjustments to the amount due to or from the IHC Program based upon corrections to carrier submissions;

iv. Interest charges due from a carrier for late payment of amounts due to the IHC Program; and

v. Other records required by the Board.

5. The Board shall maintain a general ledger which shall be used to produce the IHC Program's financial statements in accordance with generally accepted accounting principles. The balances in the general ledger shall agree with the corresponding balances in subsidiary ledger journals.

(f) The Interim Administrator or subsequently appointed Administrator shall prepare an annual financial report to be delivered to the Commissioner and each member of the Board by September 30 of each year beginning in 1994. The annual report shall fairly present the financial condition of the IHC Program for the preceding fiscal year.

1. All accounts shall be reconciled and trial balances shall be determined monthly.

2. Financial statements in a form approved by the Board shall be prepared and delivered to each member of the Technical Advisory Committee and the Commissioner on a quarterly basis.

11:20-2.8 Audits

(a) The Board shall have an annual audit of its operations conducted by a qualified independent certified public accountant.

1. The auditor shall be selected and approved by the Board through a competitive bidding process of certified public accountants qualified in New Jersey to perform audits of the type of entity.

2. The annual audit shall include the following items:

i. A review of the handling and accounting of assets and monies of the IHC Program;

ii. A determination that administrative expenses have been properly allocated and are reasonable;

iii. A review of the internal financial controls of the IHC Program;

iv. A review of the annual financial report of the IHC Program; and

v. A review of the calculation by the IHC Program of any assessments of carriers for net losses.

3. A copy of the annual audit and related management letters shall be delivered to each Director and to the Commissioner. The annual audit report shall be reviewed by the Technical Advisory Committee, which shall present its recommendations to the Board for implementation of findings and recommendations made by the auditor. The actions adopted shall be reported to the Commissioner.

(b) The Board may, from time to time, direct that a member carrier arrange, or the Board may arrange, to have an audit conducted by an independent certified public accountant and a copy of the audit report of the member carrier delivered to the Board. All information regarding an audit of a member carrier conducted pursuant to this subsection shall be confidential and protected from disclosure by the member carrier, by the auditing firm, by the Board and the Commissioner.

11:20-2.9 Records

(a) The Board shall provide for the maintenance and retention of its official records, and may delegate this function to the Interim Administrator or subsequently appointed Administrator.

(b) The Board's records shall include the following:

1. Minutes of all Board meetings;

2. Written reports and recommendations of committees to the Board;

3. Informational and other filings made by carriers with the Board pursuant to the Act or the Board's rules, including rate and form filings, loss ratio filings, reports of net earned premium and reports of net paid losses;

4. The rulemaking file on rules proposed or adopted by the Board, including all comments received;

5. The Plan of Operation and any amendments thereto;

6. Records concerning the election of Directors and appointment of committees and committee members;

7. Determinations on requests for exemption by carriers;

8. All dispositions on matters of complaints and disputes;

9. Other actions by the Board required by the Act; and

10. Such other specific records as the Board may from time to time direct or as may be required by law.

(c) The records set forth in (b) above shall be subject to public inspection and copying pursuant to the "Right-To-Know" Act, N.J.S.A. 47:1A-1 et seq., except that information in filings de-

termined by the Board by regulation to be confidential and proprietary shall not be subject to public inspection and copying.

(d) For the purpose of disseminating information about the IHC Program, the Board shall maintain a mailing list of carriers and other interested parties.

1. The mailing list of member carriers initially shall be based upon the member carriers' addresses filed with the Department pursuant to N.J.A.C. 11:1-25. The Board may proceed to develop its own list of member carriers.

i. Upon any change in name or mailing address, a member carrier shall notify the Board in writing no later than 10 days from the date the new name or address becomes effective.

ii. Unless the Board is notified otherwise as provided above, the name and mailing address of a member carrier shall be deemed correct and communications mailed to the name and address on file shall be deemed received by the member carrier.

2. Persons other than member carriers who wish to receive communications from the Board, including proposed rules, actions and public notices, may request to be placed on the Board's mailing list as an interested party. Until the Board receives written notice of a change in name or address from an interested party, communications mailed to the name and address on file shall be deemed to be properly received. The Board shall not charge any fee for placement upon the mailing list, but the Board may charge a fee for copies of communications from the Board, which fee shall not be in excess of the actual cost of reproducing and mailing the copies.

11:20-2.10 Standard health benefits plans

(a) The Board shall establish the policy and contract forms and benefit levels (standard health benefits plans) to be made available by members.

1. In designing the standard health benefits plans, the Board shall give consideration to the types of coverage currently in force and/or available in the marketplace, individuals' preferences and the evolution of the marketplace towards managed care.

2. A committee may design or revise the standard health benefits plans, but the Board shall discuss the design and any changes thereto at a meeting open to the public prior to any vote by the Board to adopt, or modify any aspect of, a standard health benefits plan design.

3. The Board shall hold a public hearing on the standard health benefits plans or any revisions thereto prior to adopting or changing a standard health benefits plan.

i. The Board shall provide to all members and interested parties reasonable advance notice of a public hearing in accordance with the procedures set forth in the Act as amended.

ii. The Board may establish procedures for a public hearing pursuant to Article III of this Temporary Plan and publish them with the notice of the public hearing.

iii. The Board shall maintain a written record of any public hearing and make it available for inspection at the office of the Interim Administrator.

4. The Board shall adopt or amend a standard health benefits plan in accordance with the procedures set forth in the Act, as amended.

i. In accordance with the procedures for taking action set forth in the Act, as amended, the Board may adopt a standard health benefits plan or modifications thereto and thereafter shall address in writing such comments as were received within a reasonable period following the adoption of the proposed action. The Board shall give due consideration to all comments received. Pursuant to the Act as amended, the Board shall, within a reasonable period of time following submission of the comments, prepare for public distribution a report listing all parties who provided written submissions concerning the intended action, summarizing the content of the submissions and providing the Board's response to the data, views and arguments contained in the submissions. A copy of the report shall be filed with the Office of Administrative Law for publication in the New Jersey Register.

(1) The Board shall identify whether it made a change in the action proposed at its own initiative or in response to one or more comments.

ii. Except as may be required by law, members shall implement amendments to the standard health benefits plans in the time prescribed by the Board.

5. The Board shall take action as necessary to keep the standard health benefits plans in compliance with State and Federal law.

6. The Board shall consider, at least annually, whether to revise the standard health benefits plans. Such consideration shall take into account comments and complaints from covered individuals, members, and producers; trends in the small employer group and large employer group markets; actions of State and Federal agencies; and actions of the New Jersey Legislature and Congress.

(b) Members shall submit to the Board, in the care of the Interim Administrator or subsequently appointed Administrator, a certification that sets forth that the standard policy and application forms will be used in accordance with the requirements of N.J.A.C. 11:20-3.2 and 4.1.

1. As a transitional measure, members may, for a period of time, use alternative policy and application forms which are in substantial compliance with the standard policy and application forms. If alternative forms are to be used, or if the member offers a standard health benefits plan through or in conjunction with a managed care network, the member shall file the forms with the Board, in the care of the Interim Administrator or subsequently appointed Administrator, along with a certification that the forms are in substantial compliance with N.J.S.A. 17B:27A-2 et seq. and N.J.A.C. 11:20. The filing shall also include an identification of the differences between the filed forms and the standard forms.

2. No member shall issue a standard or alternative health benefits plan until a full schedule of corresponding rates has been filed with the Board in accordance with N.J.A.C. 11:20-6.

3. The Interim Administrator or subsequently appointed Administrator shall forward each certification and/or policy form and application form to the Chair of the Forms Committee within five business days of its receipt and each rate filing to the Chair of the Technical Advisory Committee within five business days of its receipt. The Interim Administrator or subsequently appointed Administrator shall retain at least one copy of each certification and/or policy form and application form and each rate filing submitted on file for proper record retention.

4. The Chair of the Forms Committee shall present the Board with a list of all certifications and alternative policy and application forms filed.

5. The Forms Committee shall review all certifications and alternative policy and application forms filed. For each alternative policy and application form, the Forms Committee shall review the forms for a recommendation to the Board as to whether or not the forms are in substantial compliance with the standard health benefits plans and application forms. The following guidelines shall be used to evaluate whether alternative forms are in substantial compliance:

i. All coverage, coverage limits, and exclusions set forth in the standard forms are included;

ii. The inclusion of words, terms and descriptions not contained in the standard policy forms does not change the meaning or effect of any material aspect of the standard form;

iii. The exclusion of words, terms, and descriptions contained in the standard forms does not change the meaning or effect of any material aspect of the standard forms;

iv. The application form includes all information on the standard form, even information which applicants are required to complete at their option; and

v. The formatting of the forms allows for easy comparison with the standard forms by consumers and the Board.

6. For any alternative form which the Forms Committee finds not to be in substantial complaince based on the guidelines of (b)5 above, the Forms Committee shall contact the submitting carrier in writing advising them of the finding including details of the noted discrepancies between the alternative form submitted and the standard form. The Carrier shall be provided the opportunity to amend the filing within a 30 day period. Any amended filing shall be reviewed according to the guidelines of (b)5 above for a recommendation to the Board.

7. The Chair of the Forms Committee shall present the Board with copies of the certifications and alternative policy and application forms reviewed. For each alternative and/or amended form, the Chair of the Forms Committee shall include a recommendation that, based on the guidelines of (b)5 above, the forms are or are not in substantial compliance with the standard forms.

8. The Board shall review those certifications, policy and application forms, along with any recommendations specific thereto presented by the Forms Committee and shall determine whether such forms are in substantial compliance with the standard health benefits plans and the standard application form.

(c) The Technical Advisory Committee shall review all rates filed, and shall compile separate lists of the rates filed according to their status as follows:

1. Rate filing complete; and

2. Rate filing incomplete, with a specific request for more information recommended.

(d) The Chair of the Technical Advisory Committee shall forward the lists established pursuant to (c) above, the rate filings assigned to those lists by the Technical Advisory Committee, and the recommendations specific to those rate filings to the Chair of the Board in a timely manner.

(e) The Board shall review those rate filings assigned to the list established pursuant to (c) above, and any recommendations specific to such rate filings and shall determine whether such rate filings are complete. Upon a determination by the Board that a rate filing is incomplete, the Board shall send notice of such determination to the affected member as specified at N.J.A.C. 11:20-6 through the Interim Administrator or subsequently appointed Administrator and shall return the lists and rate filings to the Interim Administrator or subsequently appointed Administrator to be placed on file for proper record retention.

(f) Following the return of each list established by the Technical Advisory Committee pursuant to (c) above, the Interim Administrator or subsequently appointed Administrator shall forward to the Commissioner and the Public Advocate a copy of the rate filings and a statement that the rate filings have been accepted as received or that additional information has been requested. The Interim Administrator or subsequently appointed Administrator shall forward additional information received to the Technical Advisory Committee, the Commissioner and the Public Advocate as soon as it is received.

11:20-2.11 Assessment for 1992 total reimbursable net paid losses

(a) The IHC Program Board may assess members for 1992 reimbursable net paid losses as an advance interim assessment, as may be necessary, pursuant to its authority under N.J.S.A. 17B:27A-11a and according to the procedures set forth in this Temporary Plan.

(b) The IHC Program Board shall determine the total reimbursable net paid losses, if any, for calendar year 1992 based upon the information submitted by members on or before June 28, 1993 to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report, set forth as Exhibit K in the Appendix to N.J.A.C. 11:20, completed in accordance with N.J.A.C. 11:20-8. Such a determination shall be made by the IHC Program Board on or about July 8, 1993.

1. The reimbursable net paid losses for each member reporting net paid losses in 1992 shall not exceed the lesser of $10,000,000 or 50 percent of the member's reported net paid losses.

2. No performance standards shall be applicable to any member for purposes of determining a member's reimbursable net paid losses for 1992.

3. The total reimbursable net paid losses for 1992 shall be the aggregate of the reimbursable net paid losses for all members reporting net paid losses in 1992.

(c) Every member shall be liable for a portion of the total reimbursable net paid losses for 1992 unless a member has reported a net paid loss amount that has been included by the IHC Program Board in the total reimbursable net paid losses for 1992.

1. The IHC Program Board provided notice to members in writing on July 8, 1993 of the total reimbursable net paid losses for 1992 and whether the member may or may not be liable for a portion of the total reimbursable net paid losses for 1992.

2. No later than 90 days following the preliminary notice by the IHC Program Board of a member's preliminary liability for a portion of the total reimbursable net paid losses for 1992, the IHC Program Board shall notify each member by invoice of the dollar amount being assessed on an interim basis against the member for its portion of the total reimbursable net paid losses for 1992.

3. The IHC Program Board shall provide notice to members in writing on or before November 1, 1993 of the first reconciliation of the assessment for 1992 reimbursable net paid losses which will include adjustments in market share and adjustments made for deferrals granted on or before October 20, 1993.

4. The IHC Program Board shall notify each member of the final reconciliation of the assessment and reimbursement for 1992 reimbursable net paid losses by invoice stating the dollar amount then due or credit, if any, against future assessments by April 1, 1994. As a result of the final reconciliation, any monies determined to be owed to or by Board, shall be calculated without provision for interest.

(d) Each member's assessment amount shall be determined by multiplying the member's adjusted market share, to be determined as described in (d)1 through 3 below, against the total reimbursable net paid losses for 1992, except that no member shall be liable for an assessment amount greater than 35 percent of the total reimbursable net paid losses for 1992.

1. The IHC Program Board shall determine each member's adjusted market share by comparing the member's net earned premium for calendar year 1992 to the net earned premium of all members excluding members with 1992 reimbursable net paid losses for calendar year 1992, as reported by each member on or before June 28, 1993 to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report, set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit a Carrier Market Share and Net Paid Loss Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement filed with the Department.

2. Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by a member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members based on their respective adjusted market shares.

3. A member's assessment in amounts exceeding the 35 percent limit shall be apportioned to other members, based upon their respective adjusted market shares, until such other members reach the 35 percent limit or the total reimbursable net paid losses for 1992 are fully assessed, whichever occurs first.

(e) Assessment amounts are due and payable upon receipt of an invoice by a member for the assessment. Payment shall be by bank draft made payable to the Treasury—State of New Jersey, IHC Program, c/o the New Jersey Department of Insurance, 20 W. State Street, CN-325, Trenton, N.J. 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid, accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (e)1i above. If a carrier makes an error relating

to or involving an assessment or any other error resulting in nonpayment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(f) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with N.J.A.C. 11:20-11.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (e) above, to be held in an interest bearing escrow account in accordance with the procedures set forth in (g) below, pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (f)1 above and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (e)1 above, accruing from the date of the invoice for the assessment.

(g) The Interim Administrator (or Administrator) shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose. The Board shall approve the disbursement of all funds then in the account, and any payments to those members determined by the IHC Program Board as having reimbursable net paid losses for 1992. Disbursement shall be in proportion to the member's share of the total reimbursable net paid losses for 1992, until all such available funds have been paid out, or a member's reimbursable net paid losses for 1992 have been reimbursed, whichever comes first.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed to members having reimbursable net paid losses in 1992, until such time as the dispute has been settled or concluded with the disputing member, or the deferral denied, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed to members having reimbursable net paid losses in 1992 in accordance with (g) above, along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Interim Administrator (or Administrator) receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

(h) An assessment for the 1992 reimbursable net paid losses, as an advance interim assessment, shall be credited as an offset against any regular assessment due following the close of the following year as required by N.J.S.A. 17B:27A-11a.

11:20-2.12 Assessments for administrative expenses and organizational and operating expenses

(a) Every member shall be liable for a portion of the annual administrative expenses of the IHC Program. On or about April 15 anually the IHC Program Board shall notify each member by separate invoice of the dollar amounts being assessed against the member for its portion of the final administrative expense total for the preceding calendar year, if any.

1. Such notice shall include a brief summary of the final administrative expenses and shall credit the member for any interim administrative expense assessments paid.

2. If a member has advanced a sum or sums of money to the IHC Program to cover some portion of the IHC Program's administrative expenses, those sums advanced shall be credited against the member's assessment amounts.

3. Each member's final annual assessment for administrative expenses shall be reduced by any deferred assessment paid by assessed carriers in proportion to the original assessment made to cover the deferred amount.

(b) The Board, at its discretion, may make an interim assessment on a monthly basis or such other periodic basis as necessary to ensure the availability of funds to meet operating expenses as well as to cover estimated losses.

(c) All members shall be assessed for a proportionate share of final administrative expenses for the preceding calendar year on the basis of the ratio of the member's health benefits plans net earned premiums for that calendar year to the total of all members health benefits plans net earned premiums for that calendar year. Net earned premiums shall be determined as reported by each member to the IHC Program Board in the Carrier Market Share and Net Paid Loss Report as set forth as Exhibit K of the Appendix to N.J.A.C. 11:20, and completed in accordance with N.J.A.C. 11:20-8. Should a member fail to submit a Carrier Market Share and Net Paid Loss Report as required by N.J.A.C. 11:20-8, the member's market share shall be determined by the IHC Program Board based upon the premium set forth in the member's most recent Annual Statement filed with the Department.

(d) Interim assessments shall be made on the same basis as in (c) above, but shall use the net earned premium from the preceding calendar year.

(e) Assessment amounts for members granted a deferral by the Commissioner, or subject to dispute by the member wherein the dispute is settled in favor of the disputing member, shall be apportioned to other members on the same basis as set forth in (c) above.

(f) Assessment amounts are due and payable upon receipt by a member of an invoice for the assessment. Payment shall be by bank draft made payable to the Treasury—State of New Jersey, IHC Program, c/o the New Jersey Department of Insurance, 20 W. State Street, CN-325, Trenton, NJ 08625.

1. Members shall be subject to payment of an interest penalty on any assessment, or portion of an assessment, not paid within 30 days of the date of the invoice for the assessment, unless the member has been granted a deferral by the Commissioner of the amount not timely paid.

i. The interest rate shall be 1.5 percent per month of the assessment amount or any portion thereof not timely paid accruing from the date of the invoice for the assessment.

ii. Payment of an assessment, or portion of an assessment for which an interest penalty has accrued, shall include the interest penalty amount accrued as of the date of payment; otherwise, payment shall not be considered to be in full.

iii. Good faith errors that are reported to the Board by a member within 60 days of their occurrence shall not be subject to the interest penalty set forth in (f)1i above. If a member makes an error relating to or involving an assessment or any other error resulting in nonpayment or underpayment of funds, the member shall make immediate payment of additional amounts due.

2. Members that dispute whether they are subject to an assessment, or dispute the amount of assessment for which they have been determined liable by the IHC Program Board, shall be liable for and make payment of the full amount of the assessment invoice when due, including any interest penalty accruing thereon, until such time as the dispute has been resolved in favor of that member, or, if a contested case, the IHC Program Board has rendered a final determination in favor of that member in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B-1 et seq.

(g) A member may request that the Commissioner grant a deferral of its obligation to pay an assessment in accordance with procedures established by the Commissioner.

1. If a member files a proper request for deferral within 15 days of the date of the invoice, that member may make payment of the amount of the assessment invoice pursuant to (f) above, to be held

in an interest bearing escrow account in accordance with the procedures set forth in (h) below pending final disposition by the Commissioner of the deferral request.

2. If the member withholds payment, as permitted pursuant to (g)1 above, and the Commissioner denies the request for deferral, the member shall be subject to payment of the interest penalty set forth in (f)1 above, accruing from the date of the invoice for the assessment.

(h) The Interim Administrator (or Administrator) shall deposit all monies received from the Treasury pursuant to this section in an interest bearing account maintained by the IHC Program Board for that purpose.

1. Amounts of assessment in dispute or subject to a deferral request shall not be disbursed by the Board until such time as the dispute has been settled or concluded with the disputing member, or until final disposition of the request for deferral by the Commissioner, except that any portion of an assessment not in dispute or subject to the deferral request, or portions no longer disputed or subject to a deferral request, may be disbursed immediately, along with any applicable interest penalty amounts paid or interest earned while held in escrow by the Board.

2. Amounts of assessment disputed or subject to deferral wherein the dispute is resolved in favor of the disputing member, or a deferral is granted, shall be returned to the appropriate members within 15 days of the date that the Administrator receives notice of the determination by the IHC Program Board or the Commissioner, as applicable, along with the proportionate amount of interest penalty, if any, paid by the member for late payment of the amount, and the proportionate amount of the interest earned on that amount while the amount was held in escrow by the Board.

11:20-2.13 Notice of request for deferral

A member requesting a deferral from the Commissioner of an assessment amount shall concurrently provide notice of such request in duplicate to the Interim Administrator (or Administrator) in order to preserve its right to any monies paid pursuant to the invoice for assessment.

11:20-2.14 Failure to pay assessments

If a member is determined liable for an assessment fails to pay the full amount of the assessment and applicable interest, if any, within 60 days of the date of the invoice, and has neither submitted notice that it is seeking a deferral from the Commissioner, nor requested a hearing, the IHC Program Board may provide to the Commissioner a notice of the member's failure to make payment along with a recommendation to revoke the member's authority to write any health benefits plans or other health coverage in this State. A copy of this notice shall be sent to the member by registered mail at the same time that the notice is sent to the Commissioner. In accordance with the Act, failure to pay assessments shall be grounds for removal of a member's authority to write health coverage of any kind in this State.

11:20-2.15 Penalties/adjustments and dispute resolutions

(a) A member seeking to challenge the amount of an assessment must do so within 20 days of receiving the notice of the assessment following the procedures established by the Board.

(b) A member which disputes being subject to an assessment and wishes to contest that issue shall file its appeal with the IHC Program Board no later than 20 days of receiving the notice of assessment following the procedures established by the Board.

(c) Concurrent with its challenge to the assessment, a member shall advise the Board in detail of the reasons why the assessment is inaccurate or not appropriate and submit all documentation that supports or tends to support the member's position. The member shall also advise at this time whether a hearing is requested.

(d) If a hearing is requested, within 30 days of its receipt thereof, the Board shall determine whether the matter constitutes a contested case. If the matter is determined to be a contested case, the Board shall determine whether to hear the matter or refer it to the Office of Administrative Law for a hearing 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. If the matter does not constitute a contested case, the Board will review the challenge itself or delegate this review to an appropriate Committee to make a recommendation to the Board.

(e) If the Board determines that the nature or extent of errors or conduct by a member evidence activity for which penalties or sanctions are appropriate, the Board shall refer the matter to the Commissioner, Attorney General, and/or other appropriate enforcement agency, for appropriate action including the assessment of penalties and sanctions as provided by the Act, as well as any other penalties permitted by law. Nothing herein shall be construed to limit the authority of the Commissioner, the Attorney General or any law enforcement agency to take appropriate regulatory or enforcement action with respect to violations of law and regulations.

11:20-2.16 Indemnification

(a) The participation in the IHC Program as a member, the establishment of rates, forms or procedures, or any other joint or collective action required by the Act shall not be the basis of any legal action, criminal or civil liability, or penalty against the IHC Program, member of the Board of Directors or any member carrier either jointly or separately except as otherwise provided in the Act.

(b) The Board shall not be liable for any obligation of the IHC Program. No Director, officer or employee of the Board or the Department shall be individually liable and no cause of action of any nature may arise against them, for any action taken or omission made by them unless their conduct was outside the scope of their employment or constituted a crime, actual fraud, actual malice or willful misconduct.

(a)

SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD

Small Employer Health Benefits Program

Adopted New Rules: N.J.A.C. 11:21-1, 3, 4, 5 and Exhibits A, B, C, D, E, F, G, H, I, J, K, L and M of the Appendix to N.J.A.C. 11:21

Proposed: July 14, 1993 in accordance with P.L. 1993, c.162, section 16, at 25 N.J.R. 3599(a) (August 16, 1993).

Adopted: October 15, 1993 in accordance with P.L. 1993, c.162, section 16 by the Small Employer Health Benefits Program Board, Maureen E. Lopes, Chairman.

Filed: October 15, 1993 as R.1993 d.553, **with substantive and technical changes** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 17B:27A-17 et seq. as amended by P.L. 1993, c.162.

Effective Date: October 15, 1993, in accordance with P.L. 1993, c.162, section 16.

Expiration Date: October 15, 1998.

These new rules were proposed and are being adopted pursuant to the procedures set forth at P.L. 1993, c.162, section 16, as therein authorized.

Accordingly, notice of the proposal of these new rules was sent for publication in three newspapers of general circulation in New Jersey, mailed to all known interested parties, and submitted to the Office of Administrative Law (OAL) for publication in the New Jersey Register.

Pursuant to P.L. 1993, c.162, section 16, interested parties were provided a comment period of at least 15 days. As set forth in the notice of proposed new rules, the written comment period ended on September 16, 1993. Additionally, a public hearing was held before the Board on September 1, 1993, in accordance with P.L. 1993, c.162, section 16. A copy of the transcript may be obtained by contacting the Interim Administrator, New Jersey Small Employer Health Benefits Program Board, SEH Box 1, c/o The Prudential Insurance Company of America, P.O. Box 4080, Iselin, New Jersey 08830.

Comments were received from numerous commenters, both oral and written. Not all comments received were responsive to the proposed rules

and accompanying appendix exhibits. The Board has responded only to those comments specifically relevant to the propposal.

Readers should note in some instances that although the rules may not have been amended, the Exhibits may have been, and both pieces of the adoption should be reviewed.

Summary of Public Comments and Agency Responses:

The Small Employer Health Benefits Program received timely comments from the following:

1. Medical Society of New Jersey
2. Leonard J. Press, O.D., F.A.A.O.
3. New Jersey State Nurses Association
4. Garden State Hospitalization Plan
5. Home Health Assembly of New Jersey, Inc.
6. Kessler Institute for Rehabilitation, Inc.
7. Northern New Jersey Chiropractic Society Legislative Committee
8. New Jersey Optometric Association
9. St. Peter's Medical Center
10. Fox Chase Cancer Center
11. CIGNA Companies
12. New York Life Insurance Company
13. Massachusetts Mutual Life Insurance Company
14. Pharmaceutical Manufacturers Association
15. Merck and Co., Inc.
16. Bristol-Myers Squibb Company
17. American Cyanamid Company
18. South Jersey Physical Therapy Associates, P.A.—Alan F. Caniglia, P.T.
19. Wayne Physical Therapy Center
20. Marlboro Physical Therapy, P.A.
21. Old Bridge Center of Physical Therapy
22. South Jersey Physical Therapy Associates, P.A.—Pamela J. Steelman, P.T.
23. New Jersey Chapter American Physical Therapy Association
24. Northern Counties Institute for Physical Therapy
25. Princeton Physical Therapy Center, P.C.
26. Raritan Valley Physical Therapy Associates, P.A.
27. Shore Orthopedic and Athletic Rehabilitation, P.A.
28. Nancy Thompson, P.T.
29. P.R.D. Physical Therapy, P.A.
30. Sports Care and Physical Rehabilitation, Inc.
31. Emens, Kegler, Brown, Hill & Ritter for Medco Containment Services, Inc.
32. Phoenix Home Life Mutual Insurance Company
33. New Jersey Association of Mental Health Agencies, Inc.
34. State of New Jersey Commission on Cancer Research
35. Home Care Council of New Jersey
36. University of Medicine and Dentistry of New Jersey
37. Career Opportunity Development Inc.
38. Gary Cupo
39. Kenneth Baldwin
40. Robert Gada
41. Leonard Sendelesky
42. Arnold Cianciulli
43. Russ Chaney
44. Jesse Wolff
45. Edmund Lawlor
46. Richard Alampi
47. Joseph Santo
48. Linda Lang
49. Francine McLean
50. Harriet Weiss
51. Kate Valentine
52. Jerry Ferrara
53. Curt Macysyn
54. Allan Boushie
55. Penni Wild

Summary of Comments and Agency Responses:

COMMENT: One commenter suggested the inclusion of more nutrition therapy benefits under the standard plan designs.

RESPONSE: The Board developed the standard plan designs as reflected in the standard policy forms, Exhibits A through G of N.J.A.C. 11:21-3.1. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. No change in the charges covered by the standard plans is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter suggested that the definition of dependents be broadened to include foster children as a matter of public policy.

RESPONSE: It is unclear what public policy the commenter is endorsing. It is the Board's belief that foster children have health care coverage provided through the placing agency (that is, the State). To the extent that that is accurate, and there is no other legal or financial dependency of the foster child upon the foster parent(s), there is no basis for expanding the definition of dependent to include foster children.

COMMENT: One commenter asked that the definition of doctor or primary care physician be clarified to recognize only doctors of medicine or osteopathy as primary care physicians.

RESPONSE: The definition of "primary care physician," a term to be used in managed care versions of the Small Employer Health Benefits ("SEH") Program plans, is intended to be consistent with the definition of the term "practitioner" appearing in the general definitions of Plans A through E. (Note that "primary care physician"has been changed to "primary care practitioner.") The carrier will define its network. While it is probable that carriers will limit their network of primary care practitioners to doctors of medicine or osteopathy, this may not be universally true. For instance, carriers which permit selection of an obstetrical practitioner may allow insureds the opportunity to select nurse midwives as opposed to medical doctors. Some carriers have found nurse midwives an economical alternative, and some insureds are more comfortable with the choice of a nurse midwife. Other examples for not so narrowly defining the term "primary care physician" may exist.

COMMENT: One commenter proposed deleting the requirement that only network or participating physicians be defined as primary care physicians, because by definition any physician practicing a primary care specialty is in fact a primary care physician.

RESPONSE: It is assumed that the commenter is referring only to the use of the term "primary care physician" as used in the HMO Plan. "Primary care physician" as specifically defined in the standard HMO plan design, is not intended nor should it be construed to have the same meaning as the term is used within general medical practice. Within the context of the HMO Plan, the term is defined appropriately, and, thus, the commenter's suggested change is not being made.

COMMENT: One commenter suggested that the use of the term primary care physician (PCP) should be avoided in the text of the policies because most people will not be familiar with it.

RESPONSE: Primary care physician (PCP) is a defined term within the standard policies. People enrolling in managed care plans will become familiar with the term through the enrollment process.

COMMENT: One commenter recommended the inclusion of reimbursement for outreach services for TB drug treatment, based on criteria to be developed by an expert panel or the Department of Health. The commenter argued that this would assure that infected individuals, many of whom are intravenous drug users and the homeless, pursue the course of therapy fully.

RESPONSE: Generally, insurers do not pay benefits for services when benefits or services are provided through a government sponsored program, or in situations in which the insured would not normally incur a charge. However, treatment of TB, in and of itself, is not excluded under the SEH Program plans. Naturally, benefits are limited to persons covered under one of the health benefits plans. Realistically, few of the people who would participate in an outreach program of this nature would be covered under one of the health benefits plans.

While the SEH Program Board will keep this recommendation under advisement, the recommendation does not appear to have any practical value. No policy changes are being made at this time.

COMMENT: One commenter asked for inclusion of a provision specifically requiring protection of the confidentiality rights of individuals who are identified as seropositive during physical examinations ordered by carriers.

RESPONSE: All carriers are required to adhere to the confidentiality requirements included in Insurance Department Bulletin 86-1 and New Jersey Department of Health rule N.J.A.C. 8:57-2.1. Additionally, all carriers and insurance organizations are subject to the Information Practices Act, N.J.S.A. 17:23A-1 et seq. No change in the standard policy forms, Exhibits A through G of N.J.A.C. 11:21-3.1, is necessary.

COMMENT: One commenter asked for an increase in primary and preventive care for newborns to $1,000 for the first year of life, in order

to accomodate guidelines of the American Academy of Pediatrics, including the recommended schedule of immunizations.

RESPONSE: The SEH Program Board has attempted to balance many divergent interests in developing the five plans. While primary care benefits were considered crucially important, and hence, those benefits are to be provided without payment of deductibles or coinsurance amounts, the overall cost of the plans is also very important for both employers and employees. It is not possible to increase the primary care benefit for the first year of life without marginally increasing the costs of the plans overall. The SEH Program Board will continue to evaluate the adequacy of the plan designs over time and the cost effectiveness of each benefit within the plan designs, but will make no change to this benefit at this time.

COMMENT: One commenter asked for inclusion of fetal surgery to correct gastrointestinal defects or cardiac abnormalities.

RESPONSE: Subject to all the terms of the standard plans (for instance, medical necessity, and cost sharing requirements), such surgery is a covered charge.

COMMENT: Several commenters stated that the $100.00 preventive care benefit under Plan A is entirely inadequate, and at least one commenter suggested that the preventive/primary care benefit be expanded for all persons over age one to $500.00 on all plans.

RESPONSE: While several commenters cite immunization costs as the reason for inadequacy of the Plan A preventive benefit, no commenter stated why the $300.00 primary care benefit in Plans B through E should be increased to $500.00 annually. In designing the plans, the SEH Program Board has attempted to balance statutory requirements, benefit cost effectiveness, and total plan cost. It is not possible to increase the primary care benefit for persons over age one without an increase in the cost of the plan. (Because these are primary care benefits, provided on a first dollar basis, insurers will anticipate maximum utilization of the benefit by most insureds.) The Board will keep the recommendations under advisment, but will make no change at this time.

COMMENT: Several commenters asked for an increase in mental health benefits and one commenter asked for a separation in benefits between inpatient and outpatient care.

RESPONSE: The commenters have not provided a reason why the benefit should be separated between inpatient and outpatient care when not subject to managed care provisions. (Note that the HMO Plan does provide coverage of service on an inpatient and outpatient basis. Additionally, the Mental Health Rider, Exhibit I within the Appendix to N.J.A.C. 11:21, provides for the benefit under Plans A through E to be subject to management, separating the benefit for inpatient and outpatient services.) In developing these plans, the Board determined it was appropriate to part with the common practice of providing benefits separately for inpatient and outpatient treatments of substance abuse and mental/nervous conditions under nonmanaged care plans. The provision of a dollar amount, the board believes, provides the practitioners and the patient with flexibility in treatment of such conditions, while providing an incentive to utilize less costly, less invasive treatments whenever appropriate.

COMMENT: Several commenters asked that coverage of autologous bone marrow transplantation for breast cancer (other than lymphoma) be included. One commenter noted that research is showing promising results of this form of treatment for metastic breast cancer, indicating that the treatment is beneficial where medically appropriate. One commenter recommended referring the issue to an expert panel.

RESPONSE: The Board agrees with some of the commenters' statements, but continues to note that the procedure, in conjunction with the high dose chemotherapy, remains an experimental and investigational procedure, as evidenced by ongoing clinical trials by the National Cancer Institute. The Board is revising the standard plans, Exhibits A through G of the Appendix to N.J.A.C. 11:21, to include coverage of expenses related to autologous bone marrow transplant and associated high dose chemotherapy for breast cancer if a person is participating in a National Cancer Institute sponsor clinical trial. Such coverage is subject to carrier preapproval.

COMMENT: One commenter asked for a decrease in the copayment requirement applicable for physician services under Plan A, stating that such a high coinsurance requirement will continue to cause high hospital admission rates for so called "ambulation care sensitive admissions."

RESPONSE: Plan A is designed primarily to provide benefits for hospital services with a modest preventive care benefit. As such, Plan A meets the statutory requirements of a basic health benefits plan. Generally, physician services rendered other than in a covered facility are not covered charges at all. Thus, reducing the coinsurance feature from 50 percent to 20 percent will not have the effect the commenter anticipates. Plan A is not designed to eliminate or reduce hospital admissions, and in that respect, differs markedly from Plans B through E and the HMO Plan. No change in the Plan A design in this regard will occur at this time.

COMMENT: One commenter asked for a decrease or lowering of the coinsurance caps applicable under Plans B through E.

RESPONSE: The commenter has provided no reason for reducing the coinsurance caps. In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. The Board considered costs, and noted that both deductibles and coinsurance limits impact on premium rates. Further, the Board noted that many employer plans currently available in the market include both higher deductibles and larger coinsurance caps, while some employer plans provide lower deductibles and caps. The Board wanted a balance, with reasonable premiums. Given those two considerations the Board believes the current coinsurance caps are reasonable. No change in the coinsurance caps is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter asked that the coinsurance cap and coinsured charge limit be clarified.

RESPONSE: Both features do not exist within a standard plan. A coinsured charge limit only applies to standard plans delivered through a managed care arrangement. In such an arrangement, different levels of coinsurance exist depending on whether one is using network or out-network services. The coinsured charge limit defines the total amount of coinsurance the individual must satisfy, whether incurred in or out of network, in order for no coinsurance amount to apply in or out of network.

COMMENT: One commenter stated that the per person lifetime limit for Plan B should be increased from $1 million to $5 million.

RESPONSE: By statute, the Board is required to set a lifetime limit of $1 million on one of the five plans. The Board believed Plan B was the most reasonable choice. The Board will not increase the limit without statutory authority.

COMMENT: One commenter stated that the Board should offer as a specific plan design that benefit package recommended by the American Medical Association, particularly since it has formed the basis for development of the benefit plan by the Federal health reform task force. The commenter enclosed an outline.

RESPONSE: The Board notes that Plans B through E and the HMO Plan are remarkably similar to that proposed by the commenter as regards covered services and supplies. The outline provided by the commenter does not address deductibles, coinsurance or copayment levels or other possible internal limits, and is lacking in certain other specific details necessary for contract design. On the other hand, the American Medical Association's plan schedules many benefits in such a manner as to make the covered charges more restrictive than those provided by the Board's plans. The Board believes that the similarities in the plans is sufficient to satisfy the commenter's concerns without changing the health benefits plans.

COMMENT: Two commenters suggested the inclusion of vision therapy benefits under the standard plan designs, citing reports that optometric vision therapy and orthoptic are at least as effective as surgery, and less costly and invasive.

RESPONSE: In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. No change in the charges covered by the standard plans is being made at this time, but the Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: One commenter asked that the definition of a nurse and practitioner be changed to conform to the legal practice of nursing as it is defined in New Jersey. Additionally, the commenter suggested that "routine" nursing care be changed to "appropriate," stating that "routine" implies custodial care, while "appropriate" requires that the right amount of care be delivered by the right level of nursing personnel.

RESPONSE: The small employer plans do not restrict the receipt of care to care received in the State of New Jersey; hence, the definition of nurse and practitioner must include criteria which can be applied more universally than the suggested defintion. The definition of nurse as it appears in the standard plans will be maintained. With respect to the distinction between "routine" and "appropriate," the Board agrees with the commenter's rationale. The reference to "routine" has been replaced by "appropriate."

COMMENT: One commenter recommended the inclusion of chiropractic care in all health benefits plans. The commenter stated that: (a) denial of the patient's choice to chiropractic care offends his or her first amendment privilege; and (b) chiropractic's clinical effectiveness and cost effectiveness is well documented, in contrast with the nonexistence of data to support disk fusion, disk surgeries, etc.

RESPONSE: Plans B through E include coverage of chiropractic services, for up to 30 visits per person per year. Plan A does not provide coverage for therapeutic manipulation (as defined). Failure to include chiropractic services or benefits in this plan does not, in the Board's opinion, violate anyone's first amendment rights. No change in this regard will be effected for Plan A.

COMMENT: One commenter recommended revision of the emergency room benefit exclusion under Plan A to restrict coverage to care received as a result of an accidental injury or the appearance of morbid symptoms for which the person is admitted within 24 hours of their occurrence.

RESPONSE: The Board believes the commenter's suggestion is too restrictive at this time. While the Board will keep the suggestion under advisement, the Plan A exclusion is not now being revised.

COMMENT: One commenter suggested revision of the sections of the standard policies which describe the effect of Medicare to make the issue of when Medicare is primary and secondary more clear.

RESPONSE: The Medicare description in the standard policy forms, as they appear in Exhibits A through G of the Appendix to N.J.A.C. 11:21, has been revised. Clarity was one of the objectives of revising the text.

COMMENT: Two commenters suggested that the term "Home Health Agency" be changed to "Home Health Care Agency" or "Home Care Agency," to denote a broadening of the usage of the more commonly understood definition. Additionally the commenter requested that the definition of "Home Health Agency" be revised to read as follows: "Home Care Agency: A company or organization which primarily provides home health care services, including skilled nursing care. Carrier will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency." The commenter doubts the ability of many agencies to meet the definition established by the Board as written.

RESPONSE: The Board agrees with the commenter in some respects, but notes that the definition of "Home Health Agency" tracks the definition established in N.J.A.C. 11:4-14.2. The Board agrees that the definition of Home Health Agency included in the standard policy forms should be revised by the deletion of the word "mainly" with respect to the provision of skilled nursing care. Otherwise, however, the Board does not agree that any changes are required at this time.

COMMENT: One commenter asked for clarification of whether or not copayments apply to home health care under the standard plan designs, set forth in Exhibits A through G of the Appendix to N.J.A.C. 11:21.

RESPONSE: Home health care is not subject to a copayment under the standard plans. Under Plans A through E, home health care charges would be subject to the deductible and coinsurance applicable under the particular plan. Under the HMO Plan, home health care is provided if preapproved without a deductible, copayment or coinsurance.

COMMENT: One commenter asked that more rehabilitation benefits be made available in the instance of catastrophic cases.

RESPONSE: The Board believes that the "Alternate Treatment" provisions as defined in the standard policy forms for Plans A through E, set forth in Exhibits A through G of the Appendix to N.J.A.C. 11:21-3.1, provides the flexibility necessary to allow carriers to expand rehabilitative benefits in the instance of a catastrophic illness or injury.

COMMENT: One commenter recommended different terms and definitions be used to define rehabilitative and extended care. The commenter also wanted a separation between the benefit for rehabilitative care and the benefit for extended care since these types of care are not interchangeable.

RESPONSE: The Plans do not restrict the receipt of care to care received in the State of New Jersey; hence, the definitions used in the standard policies must include criteria which can be applied more universally than the suggested definitions. The definitions in the standard plans will be maintained. However, the covered charges section of Plans A through E was revised to more clearly state that rehabilitative care and extended care are separate types of care.

COMMENT: Several commenters recommended covering smoking cessation aids under the standard plans, suggesting that coverage of this benefit is more cost effective than later treatment of illnesses associated with smoking.

RESPONSE: In creating the plan designs, the Board tried to balance many divergent interests and examine benefit plans prevalent in the market. The Board noted that while smoking cessation treatments are covered by some current policies, it is not common practice to cover such services. Further, the success rate of the various types of smoking cessation methods as compared to self treatment is, as yet, unclear. For that reason, no change in the charges covered by the standard plans is being made at this time. The Board will continue to evaluate the adequacy of the plan designs over time.

COMMENT: Two commenters stated that the definition of "Reasonable and Customary" be revised. The commenter stated that the requirement to consider severity of condition is contrary to current industry practice, at least with respect to initial determinations of reasonable and customary.

RESPONSE: The Board agrees with the commenter. The definition of "Reasonable and Customary" will be revised to remove mention of severity of condition and generally to be more clear in the description of how the determination of reasonable and customary will be made. However, because of the nature of the change, the Board believes additional notice and public comment is appropriate. Therefore, this change will not be made upon adoption, but rather, through proposed amendments. The proposed amendments will be filed at the same time as this adoption, and the period for comment shall be as set forth in the notice of intended action. (See publication elsewhere in this issue of the New Jersey Register.)

COMMENT: Several commenters suggested changes to the definition of "Experimental and Investigational" with respect to the impact of the definition upon prescription drugs. Several commenters stated that the policy forms' definition establishes criteria which is practically impossible for non-FDA approved drugs and "off-label" uses of FDA-approved drugs to meet. Additionally several commenters stated that the language provided in the definition is open to so much carrier interpretation that carriers could deny coverage for practically any and all prescription drug charges. One commenter requested that carriers be allowed greater discretion to use other criteria besides peer-reviewed literature to determine whether to accept or deny coverage of specific off label prescriptions. Several commenters suggested covering prescription drugs under off label conditions, if such use is recognized via specifically recognized compendia or such use is supported by clinical trial or studies reported in peer-reviewed literature.

RESPONSE: Although the Board believes that the language included in the definition of "Experimental and Investigational" with respect to drugs is generally reflective of current industry criteria, the Board agrees that less subjective criteria is available and viable. That is, the Board agrees that, if recognized in one of three established compendia, or supported by reports in peer reviewed literature, off label prescriptions should be covered. The Board notes that "support" can be eroded by conflicting publications, and thus, the Board believes that support must exist based upon a preponderance of the review articles and studies published, if any.

However, because of the nature of the change to this definition, the Board does not believe it is appropriate to make the change upon adoption. Rather, readers will note that the specific provisions are being proposed by the Board upon the same date as the filing of this adoption. The proposed changes are subject to a comment period as set forth in the notice of proposed action. (See publication elsewhere in this issue of the New Jersey Register.)

COMMENT: Several commenters suggested that carriers be allowed to apply their own pre-authorization, alternate treatment and centers of excellence features.

RESPONSE: The Board accepts the need for flexibility in this area. A carrier will be allowed not to apply these provisions if it so desires. However, if a carrier chooses to apply these features, the carrier either must use the provisions as they appear in the standard policies, set forth in Exhibits A through G of the Appendix to N.J.A.C. 11:21, or must submit the provisions they propose to substitute in the plans for review on approval. Such provisions will be required to undergo the same review process established for the standard plans.

COMMENT: Several commenters stated that there were problems with the prescription drug riders, and suggested changes. One commenter stated that the Exhibit H riders, intended for use with an indemnity plan, is incompatible with indemnity coverage, and can only be properly administered within the context of an HMO-type plan, because the riders

appear to presume some contractual control over the prescribing physician, which is lacking in an indemnity plan. Two commenters stated that certain criteria as to which drugs will be covered are criteria which cannot be administered at the point of sale. One commenter suggested that additional drugs should appear as exclusions, including oral contraceptives and Rogaine. One commenter stated that the definition of "Maintenance Drug" is unduly restrictive because it fails to include many chronic conditions that may require a course of maintenance drug therapy. The commenter suggested dispensing with the list and defining a maintenance drug as a prescription drug prescribed for 60 days or more, inclusive of refills, language used by the New York State Department of Social Services in its Medicaid program. Finally, one commenter queried whether the riders replace the prescription drug benefit under the main plan, as is typical, and if so, suggested that the riders should include some benefit for drugs obtained from non-network providers in an emergency or urgent circumstances.

RESPONSE: The Board agrees with most, but not all of the comments, and is revising the riders accordingly. The Board agrees that the definition of "maintenance drug" should be less condition specific. The Board agrees that benefits regarding emergency access to prescriptions should be included. The Board agrees that a specific exclusion for hair replacement drugs should be included, but notes that oral contraceptives are intended to be covered (along with any other prescribed birth control device). The Board will attempt to make the Exhibit H riders more indemnity compatible. Due to the nature of some of the changes, however, they cannot all be incorporated upon adoption. The Board is proposing revisions which require an additional comment period at the same time as the filing of this adoption. The comment period for these revisions is as set forth in the notice of the intended action. (See publication elsewhere in this issue of the New Jersey Register.)

COMMENT: One commenter recommended that the exclusion for eye examinations be amended to cover medically necessary eye examinations.

RESPONSE: The Board agrees with the commenter's recommendation and has incorporated the recommendations upon adoption.

COMMENT: One commenter recommended that optometry be included in the list of Specialist Doctor Benefits in the Coverd Services in the HMO plan.

RESPONSE: The list of specialties covered in this provision is not exclusive. To the extent that a referred service could be provided by an Optometrist, within the scope of the Optometrist's license, the service would be covered.

COMMENT: Several commenters called for increased physical therapy benefits to be made available under the standard plans. Several commenters stated that the proposed benefits could be inadequate for catastrophic illnesses or injuries, while other commenters suggested that 30 days per year failed to address the needs of someone who needed physical therapy for more than one incident in a year.

RESPONSE: The Board believes that the "Alternate Treatment" provisions as defined in the standard policy forms for Plans A through E, set forth in Exhibits A through G of the Appendix to N.J.A.C. 11:21, provides the flexibility necessary to allow carriers to expand physical therapy benefits in the instance of a catastrophic illness or injury. The Board does not believe that a change to the physical therapy provision is necessary in that regard. With respect to multiple episodes in a calendar year, the Board does not currently agree that a change is necessary. The Board has had to consider divergent interests in developing the standard plans, and readily admits that, while covered services are comprehensive, the plans cannot be all things to all people. The plans are designed primarily to provide benefits under the most typical situations, not the atypical. All commenters stated that, under ordinary circumstances, the benefits are adequate. The Board believes it has met its goals, although, as with all covered services, the Board will continue to review the adequacy of the benefit design.

COMMENT: One commenter asked whether the standard policy forms are subject to a file and use standard or prior approval.

RESPONSE: Carriers are not required to file the standard policy forms for approval with the Small Employer Health Benefits Program Board. The Board will develop a certification form which the carrier will be required to file with both the Board and the Department of Insurance.

COMMENT: One commenter asked whether the standard policy forms could be reformatted. Specifically, the commenter questioned whether the order of policy provisions could be changed.

RESPONSE: No, the arrangement of policy provisions is not variable. The provisions themselves must remain as written and as formatted in the standard policy forms. One of the goals of creating standard policy forms was to make the standard plans easy to compare regardless of the carrier selling the plans. Reformatting of the standard plans could complicate the comparison process.

COMMENT: One commenter stated that it is unclear how the reference to N.J.A.C. 11:21-3.1(c) at N.J.A.C. 11:21-3.1(d)4 would apply to non-HMO plans (that is, PPO plans), since subsection (c) concerns payment levels which do not appear to be useful for PPO plans.

RESPONSE: Indemnity plans offered in conjunction with a managed care arrangement (preferred provider arrangement or PPO) may be offered with a "gatekeeper" mechanism or without a "gatekeeper." When a PPO is utilized without a gatekeeper system, copayment levels probably would not be useful, just as the commenter points out. However, under that situation, carriers need not comply with N.J.A.C. 11:21-3.1(d)4. Rather, N.J.A.C. 11:21-3.1(d)4 applies to a preferred provider arrangement which utilizes a gatekeeper and the in-network benefits appear very similar to the services under an HMO plan. In that instance, the Board is requiring that the in-network benefit must conform with the HMO options.

COMMENT: One commenter asked if a carrier utilizes a managed care arrangement, must it offer the network in conjunction with all the standard plans.

RESPONSE: No, a carrier can choose to offer a managed care network with one or more of the standard plans. A carrier does not have to offer a managed care arrangement with all the standard plans.

COMMENT: One commenter stated that the plan designs refer to primary care physicians with language that does not appear to be variable. The commenter asks whether the intent is that all networks must use primary care physicians as gatekeepers.

RESPONSE: Carriers may use preferred provider networks with and without gatekeepers. The plan designs provide language for both scenarios. Readers should refer to the plan headings "Preferred Provider Organization Provisions," which is intended for use with nongatekeeper-oriented networks, and "Point of Service Provisions," which is meant to be used where the primary care practitioner is the gatekeeper.

COMMENT: One commenter questioned whether an "employee and child" tier was established in the standard policy forms.

RESPONSE: The third rate tier in the standard policy forms (parent/child) will accommodate an employee and child rate. "Child" should be read as one or more children.

COMMENT: One commenter suggested that the definition of mental health centers in the standard policy forms be expanded to recognize those centers which are "accredited or licensed by the State of New Jersey to provide mental health services," noting that current New Jersey regulations and certification policies support the expanded definition.

RESPONSE: The Board agrees with the commenter's suggestion and has incorporated the recommended change in the definition of mental health centers.

COMMENT: One commenter stated that the proposed policy provisions suggest that coverage is only for traditional outpatient visits. The commenter requested that the Board clarify its use of "outpatient treatment," suggesting that a broad range of non-inpatient services be allowed to fall under the definition of "outpatient treatment." The commenter cites partial care as an example.

RESPONSE: Without providing more discussion as to why the commenter believes the provisions are overly restrictive, and the language to fulfill the commenter's goals, it is not clear to the Board how it should review its language, if so inclined. The Board does not believe that the language in the policy form presupposes any specific type of outpatient treatment.

COMMENT: One commenter suggested that the annual and lifetime dollar limits for the mental/nervous benefit be eliminated, or at least doubled, thereby meeting the estimated average coverage levels for behavioral health care benefit. The commenter argued that the annual limit could be reached in one average psychiatric hospitalization, but would fail to see the person through the episode so that he or she may return to work. The commenter stated that the system allows for the high expense of hospitalization, rather than promoting less costly treatment methods.

RESPONSE: The Board disagrees with the commenter's statements. The Board's intent in going to a flat dollar benefit, without requiring that some or all of a benefit be spent as an inpatient or an outpatient, was to encourage both patients (or their families) and mental health

providers to seek, to the greatest extent possible, non-inpatient hospital treatment options, and reduced inpatient hospital stays, thereby maximizing the services which can be purchased by the benefit. While the Board will continue to evaluate the design of this benefit, it does not believe that revisions as suggested by the commenter are appropriate at this time. (It should be noted that under the mental health rider, benefits for mental/nervous and substance abuse treatments are more extensive, though subject to higher levels of carrier management.)

COMMENT: One commenter called for revisions to the reasonable and customary definition contained in the standard plans A through E to more accurately reflect the Board's decision mandating use of the Prevailing Healthcare Charges System for carriers in a carrier's determination of a reasonable and customary charge.

RESPONSE: The Board understands the commenter's concern, but has determined it is wiser for both carriers and the Board to establish the standard in the rules, rather than the Exhibits. This will avoid overhauling the various Exhibits by the Board and forms by carriers whenever the reasonable and customary Board standard changes.

COMMENT: One commenter stated that the definition of "medically necessary" fails to allow the carriers sufficient flexibility to determine how best to make often difficult decisions. Specifically, the commenter was concerned about the criteria referencing the "medical standards of the community," when no ascertainable community standard exists. The commenter was also concerned about relying upon whether or not a treatment is accepted by a professional medical society, noting a frequent reluctance of medical societies to take positions on such matters.

RESPONSE: The Board agrees with the commenter's points, and has revised the definition upon adoption by deleting references to both criteria. Nevertheless, carriers are bound by the terms of the policy; there are limits to the flexibility afforded to carriers in this regard.

COMMENT: One commenter expressed concern that coverage for mammography screening is limited to those over age 50 for every other year. The commenter noted that the American Cancer society guidelines call for annual screenings for those over age 50, and one mammogram every other year for those aged 40 to 49.

RESPONSE: The commenter appears to be misinformed regarding the mammography benefits set forth by the Board. The standard plans B through E and the HMO Plan will cover charges for mammograms according to the following schedule: a) one baseline mammogram between ages 35 to 39; b) one mammogram every two years from ages 40 to 49 (or more frequently, if recommended by a practitioner); and c) one mammogram every year from the age of 50. The schedule is consistent with the guideline recommended by the American Cancer Society. (See, Exhibit F of the Appendix to N.J.A.C. 11:21, the "Mammogram Charges" paragraph of the "Covered Charges with Special Limitations" subsection of the "Health Benefits Insurance" section.)

Mammograms may be covered more frequently under Plans A through E through the preventive care benefit, subject to the annual per person maximum for preventive care.

COMMENT: One commenter expressed concern about the ability of carriers to find reinsurance carriers that will reinsure unlimited benefit plans, as well as the carriers' abilities to fund the level of benefits from their own resources. The commenter proposed a maximum $2 million payable on a per cause basis for Plans A, C, D and E.

RESPONSE: The Board disagrees with the suggestion and questions the basis of the commenter's concern. The commenter is reminded that the Small Employer Health Benefits Program contains a type of reinsurance mechanism already for those carriers that elect to be "reinsuring" carriers. If the commenter truly doubts its ability to find a reinsurance carrier or to fund the plans sufficiently, it may want to consider electing to be a "reinsuring" carrier. Frankly, however, the Board believes reinsurance coverage is or will be available for this market if carriers want it. The Board does not believe it is necessary to put lifetime maximums on Plans A, C, D and E. (Note that Plan B has a $1,000,000 lifetime maximum, because one plan was required by statute to have a $1,000,000 lifetime maximum.)

COMMENT: One commenter stated that the separate copayment on hospital confinement (Plans A and B) adds unnecessary administrative complexity, and did not understand why that approach was used.

RESPONSE: Costs and pricing were the basis for the per diem copayment. The Board believes that the copayment will provide an additional element of cost containment and reductions in premium rates for those two plans.

COMMENT: One commenter stated concern that no statutory plan was designed to provide medical coverage supplemental to a basic hospital or basic hospital and surgical plan. The commenter stated that beginning March 1, 1994, it would be forced to cancel coverage for more than 150 New Jersey based employers (apparently having a hospital plan with a medical wraparound), in part because the hospital plan carrier will not be offering the hospital plan, and the commenter lacks the underlying claims data to accurately determine fair and adequate prices to be able to offer a comprehensive alternative.

RESPONSE: Statutorily, the Board was never in a position to develop a hospital only plan and medical wraparound plan. Further, the commenter should be aware that even if the Board had been able to do so, carriers would still be required by statute to offer the remaining nonwraparound plans in order to provide the wraparound plan, which is to say, the commenter's claims data base problem would still be a problem.

The Board assumes that the commenter and the hospital plan carrier are aware that all of the hospital plans and medical wraparound plans they currently provide do not have to be cancelled on one date (March 1, 1994). Rather, these plans should be nonrenewed on their first anniversary date on or after February 28, 1994.

The Board notes that under P.L. 1993, c.162, carriers are permitted to try to coordinate with hospital service corporations in New Jersey to produce combined hospital and medical plans meeting all of the requirements of the five standard SEH Program plans, A through E.

COMMENT: One commenter stated that by defining "doctor" and "practitioner" as a person the carrier "is required by law to recognize" could be construed to mean only that a medical doctor is a recognized provider under the new policies. The commenter states that, if the Board means to recognize someone in addition to medical doctors, the definitions should be clarified, otherwise the Board is doing a disservice to the public as a whole.

RESPONSE: By statute, carriers are required to recognize a number of health care providers (acting within the scope of their licensure, and providing covered services) in addition to medical doctors. These additional health care providers include, for instance, chiropractors, optometrists, psychologists, nurse midwives. Because these providers are required to be recognized by statute (as an example, see N.J.S.A. 17B:27-50 and 51.1 or N.J.S.A. 17:48E-1i), and because the statutes do change from time to time, the Board believed it unnecessary, and possibly unwise, to try to list providers who must be recognized.

COMMENT: One commenter remarked with respect to parents of dependents with a mental or physical handicap, that it appears there is no portability of coverage to a new carrier.

RESPONSE: The commenter may have misunderstood the language in the policy forms, in that, indeed, portability of coverage exists for all insureds who transfer from another policy with no interviewing lapse in coverage. For this reason, the Board will make no change to the policy forms at this time.

COMMENT: One commenter stated that in Exhibits A, B, C, D and E, in the "Schedule of Insurance and Premium Rates," under "Daily Room and Board Limits," the statement "For special care units, carrier will cover charges up to hospital's actual daily room and board charge" should be changed to ". . . carrier will cover charges up to the hospital's actual daily special care unit room and board charge."

RESPONSE: The Board does not believe this clarification is necessary, since the special care units charges that will be covered is already distinguished from private and semi-private room charges.

COMMENT: One commenter stated that immunization agents are listed under "Noncovered Services and Supplies" (Exhibit G), and questioned whether this included rabies, hepatitis, tetanus and pneumococcal vaccines. Additionally, the commenter stated that preventive measures such as these deserve more cost-benefit analysis.

RESPONSE: The commenter is incorrect with regard to the statement that immunization agents are listed under "Noncovered Services and Supplies." Such services will be covered to the extent medically necessary and all other applicable terms of the contract.

COMMENT: One commenter stated that the precertification penalties (50 percent) are too onerous. The commenter noted that its plan had a $500.00 penalty.

RESPONSE: The Board neither agrees nor disagrees with the commenter, but the Board does believe that greater flexibility should be afforded carriers in establishing the precertification penalties. Because of the nature of the change, the Board believes an additional notice and comment period is appropriate. A proposal to amend the precertification penalty to allow variability in the penalty is being filed

by the Board at the same time as the filing of this adoption. The comment period is as established in the notice of intended action. (See publication elsewhere in this issue of the New Jersey Register.)

Summary of Changes Upon Adoption:

1. In light of N.J.S.A. 17B:27-12's requirement that a policy may not be contested after it has been in force for two years from its date of issue, the paragraph "Incontestability of this Policy" section of Exhibits A, F, and G has been revised by the addition of text indicating that the two year period runs from the effective date of the policy.

2. The paragraph "Termination of the Policy—Renewal Privilege" in the "General Provisions" section of Exhibits A, F, and G has been adjusted to comply with P.L. 1992, c.162, which enumerates those circumstances under which a carrier may terminate a small employer health benefits plan so that a carrier will not have the right to terminate the policy if the employer's place of business is moved outside of the State of New Jersey.

3. The paragraph "Limitations of Actions" in the "Claims Provisions" section of Exhibits A, F and G has been adjusted to comply with the requirements of N.J.S.A. 17B:27-46 wherein an action for recovery must be brought by the covered person.

4. In compliance with the definition of employee under P.L. 1992, c.162, the paragraph "Employee" in the "Definitions" section of Exhibits A, F and G has been amended to provide that temporary or substitute employees are not eligible for coverage under the policy.

5. In light of N.J.S.A. 17B:27-30's requirement that coverage be extended beyond a policy's limiting age for certain incapacitated children, the paragraph "Incapacitated Children" in the "Dependent Coverage" section of Exhibits A, F and G has been adjusted to clarify that continuing coverage shall be available to such dependent in the event the small employer transfers coverage from one small employer carrier to another.

6. The paragraph "When Continuation Ends" in the "Continuation Rights" section of Exhibits A, F and G has been adjusted to conform with P.L. 1992, c.162 which identifies coverage under a health benefits plan.

7. In light of N.J.S.A. 17B:26-2i which requires a conversion privilege for a spouse in the event of divorce, the paragraph "Exception" in the "Conversion Rights for Divorced Spouses" has been clarified to delete the requirement that the spouse have been covered under the plan for three months.

8. All references to the term "Non-Network Provider" in the "Schedule of Insurance" and "Premium Rates Example PPO" section of Exhibits A and F have been changed to "Out-Network Provider" consistent with adopted N.J.A.C. 11:21-3.1(d).

9. In light of the requirements of the Federal Omnibus Reconciliation Act of 1993 that an adopted child may not be subject to a pre-existing condition limitation if enrolled for coverage within the enrollment period, the paragraph preceding the "Pre-Existing Conditions" paragraph in the "Health Benefits Insurance" section of Exhibits A, F and G has been adjusted accordingly.

10. The paragraph "Extra Continuation for Disabled Qualified Continues" in the "Continuation Rights" section of Exhibits A, F and G has been adjusted to comply with the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 to clarify that the qualified continuee is responsible for the additional premium which may be required during the extended disability.

11. The paragraph "When Continuation Ends" in the "Continuation Rights" section of Exhibits A, F and G has been adjusted to comply with the Federal Family Medical Leave Act of 1993 to provide that coverage is terminated upon non-payment of the required premium.

12. In light of the requirements of the Age Discrimination in Employment Act dealing with the election of Medicare as primary or secondary coverage, the section "How This Policy Interacts with Medicare" has been adjusted to clarify that Medicare coverage is primary for those employees whose employer is not subject to the Act.

13. The paragraph "Co-Insurance Caps" in the "Schedule of Insurance and Premium Rates" section of Exhibits B, C, D and E has been adjusted to clarify the coinsurance cap calculation to list those charges which cannot be utilized in the calculation of the coinsurance cap.

14. The paragraph "Cash Deductible" in the "Definitions" section of Exhibits A and F has been adjusted to clarify the cash deductible calculation to list charges and payments which are not included in the calculation.

15. The paragraph "The Primary Care Physician" in the "Point of Service Provisions" section of Exhibits A, F and G has been adjusted to utilize the term Primary Care Practitioner as defined in the plan.

16. The paragraph "Hospital Co-Payment Requirement" in the "Health Benefits Insurance" section of Exhibits A and E has been adjusted to refer to Period of Confinement as defined in the plan.

17. The paragraph "Therapeutic Manipulation" in the "Covered Charges with Special Limitations" section in Exhibits F and G has been adjusted to substitute therapeutic for spinal. A similar change was made in the paragraph "Payment Limits" in the "Schedule of Insurance and Premium Rates" section of Exhibits B, C, D, and E to reference therapeutic manipulation benefits.

18. The paragraph "Premium Rates" in the "Schedule of Insurance and Premium Rates" section in Exhibits A, B, C, D and E has been adjusted to clarify that only the policy's initial rates must be included in the schedule.

19. The paragraph "Premium Amounts" in the "General Provisions" section in Exhibits A, F, and G has been adjusted to clarify that premiums are affected based upon dependents covered under the policy.

20. The paragraphs "Payment of Premiums—Grace Period and Termination of the Policy—Renewal Privilege" in the "General Provisions" section in Exhibits A, F and G has been adjusted to delete erroneous wording and to cross reference the grace period liability in the Termination of the Policy—Renewal Privilege paragraph so as to clarify that the policyholder remains liable for the premiums during the grace period.

21. The paragraph "Clerical Error—Misstatements" in the "General Provisions" section in Exhibits A, F and G has been adjusted to clarify that a clerical error will not invalidate the policy.

22. The paragraphs "Dependent Eligibility Date" and "Employee Eligibility Date" in the "Definitions" section of Exhibits A, F and G have been expanded to simplify the enrollment and effective date provisions by defining these terms to clarify when coverage begins.

23. The paragraph "Hospice" in the "Definition" section of Exhibits A, F and G, the paragraph "When Dependent Coverage Ends" in the "Dependent Coverage" section of Exhibits A, F and G, and the paragraph "Hospice Care Charges" in the "Health Benefits Insurance" section of Exhibits A, F and G have been revised in a manner consistent with the language utilized in the policy forms adopted by the New Jersey Individual Health Board at N.J.A.C. 11:20-3.1(a)1 through 6. There is no change in the level of benefits provided.

24. All references in Exhibits A, F and G to the Social Security Act have been adjusted to clarify that reference is made to the United States Social Security Act.

25. The paragraphs "Enrollment Requirement" and "When Employee Coverage Starts" in the "Employee Coverage" section of Exhibits A, F and G and the paragraphs "Enrollment Requirement and When Dependent Coverage Starts" in the "Dependent Coverage" section of Exhibits A, F and G have been adjusted to clarify the employee and dependent enrollment and effective date requirements to provide that coverage becomes effective on an employee's eligibility date provided the employee enrolls within the enrollment period and agrees to make any required premium payment.

26. The "Point of Service Provisions" section of Exhibits A and F has been adjusted to clarify the operation of a point of service plan to explain those circumstances under which only out-network benefits will be provided.

27. The paragraph "Charges While Hospitalized" in the "Health Benefits Insurance" section of Exhibit A has been adjusted to clarify that hospital outpatient clinic charges are not covered under the plan.

28. The paragraph "Testing Charges" in the "Health Benefits Insurance" section of Exhibit A has been adjusted to clarify that x-ray and laboratory tests are only covered when performed in connection with a planned hospital admission or surgery.

29. The paragraph "Practitioner's Charges for Non-Surgical Care and Treatment" in the "Health Benefits Insurance" section of Exhibit A has been adjusted to clarify that practitioner's charges incurred by a covered person while hospitalized are covered charges.

30. The definition of "Cognitive Rehabilitation Therapy" in the paragraph "Therapy Services" in the "Health Benefits Insurance" section of Exhibits A, F and G has been adjusted to clarify cognitive rehabilitation as regards a congenital anomaly.

31. The paragraph "Important Notice" preceding the "Utilization Review Features" section of Exhibits A and F has been adjusted to clarify that the carrier is not responsible for any results arising from an in-

dividual's participation in a utilization review program. The remaining text in the "Utilization Review Features" section has been reproposed to permit a carrier to utilize such features at its option.

32. The "Exclusions" section in Exhibits A, F and G has been adjusted to clarify that: (1) cosmetic surgery required as a result of illness will not be a listed excluded charge, (2) exams to determine the need for, or to adjust, hearing aids will be excluded charges, and (3) any drug which is used by the covered person in connection with his or her baldness shall be an excluded charge.

33. The paragraph "Important Notice" in the "Continuation Rights" section of Exhibits A, F and G has been deleted. This text is unnecessary since no other coverages may be provided by the policy.

34. Grammatical, Editorial and Typographical Error revisions have been made throughout A, B, C, D, E, F and G where appropriate.

35. Variable allowances have been included as explained in the Explanation of Brackets, (Exhibit K, Part 1 and 2) for Plans A, B, C, D, E, and HMO Plan.

36. The definition of "Primary Care Physician" at N.J.A.C. 11:21-1.2 has been revised to substitute "Practitioner" for "Physician" to be consistent with the definition used in Exhibits A, F and G.

37. N.J.A.C. 11:21-3.1(c)3 is amended to require benefits for alcoholism treatment be covered as any other illness consistent with the benefits provided under Plans A, B, C, D and E.

38. A new paragraph has been added to the riders for prescription drug benefits set forth in Exhibit H, Part 1, Part 2 and Part 3 and Exhibit J, Part 1, Part 2 and Part 3 to clarify that any drug which is used by the covered person in connection with his or her baldness shall be excluded charges, consistent with the exclusions provided for in the prescription drug benefit under the standard health benefits plan (Exhibits A, F, and G).

39. The "Coinsurance" section in Exhibit I (the rider for mental health and substance abuse treatment management) has been clarified to provide that inpatient services which are certified as medically or clinically necessary shall not be subject to coinsurance payment.

40. The provision in proposed Exhibit F which listed "Covered Charges" beginning with "Hospital Charges" and continuing through "Pre-Admission Testing Charges" has been relocated to Exhibits B, C, D and E to properly show the correct provisions for Plans B, C, D and E.

41. The "Schedule of Insurance and Premium Rates—Example POS" which appeared in proposed Exhibit F following "Point of Service" provisions at 25 N.J.R. 3638 has been deleted as it is already located in the "Schedule of Insurance and Premium Rates" section of Exhibit F.

42. The provision in proposed Exhibit F which listed "Definitions" beginning with "Outpatient" and continuing through "Provider" has been relocated to Exhibits B, C, D and E to properly show the correct provisions for Plans B, C, D and E.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

CHAPTER 21
SMALL EMPLOYER HEALTH BENEFITS PROGRAM

SUBCHAPTER 1. GENERAL PROVISIONS

11:21-1.1 Purpose and scope

(a) This chapter implements provisions of P.L. 1992, c.162 as amended by P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.), the Small Employer Health Benefits Act. This chapter establishes procedures and standards for carriers to meet their obligations under N.J.S.A. 17B:27A-17 et seq., and establishes procedures and standards applicable for the fair, reasonable and equitable administration of the Small Employer Health Benefits Program pursuant to N.J.S.A. 17B:27A-17 et seq.

(b) Provisions of the New Jersey Small Employer Health Benefits Act and of this chapter shall be applicable to all carriers that are members of the Small Employer Health Benefits Program, and to such other carriers as the specific provisions of the statute and this chapter may state.

(c) Provisions of the New Jersey Small Employer Health Benefits Act and this chapter shall be applicable to all health benefits plans delivered or issued for delivery in New Jersey, renewed or continued on or after November 30, 1992, except as the specific provisions of the statute and of this chapter state otherwise.

11:21-1.2 Definitions

Words and terms contained in the Act, when used in this chapter, shall have the meanings as defined in the Act, unless the context clearly indicates otherwise, or as such words and terms are further defined by this chapter.

"Act" means P.L. 1992, c.162 as amended by P.L. 1993, c.162 (N.J.S.A. 17B:27A-17 et seq.), also referred to herein as the Small Employer Health Benefits Plans Act.

"Affiliated carriers" means two or more carriers that are treated as one carrier for purposes of complying with the Act because the carriers are subsidiaries of a common parent or one another, except that any insurance company, health service corporation, hospital service corporation, or medical services corporation that is an affiliate of a health maintenance organization located in New Jersey or any health maintenance organization located in New Jersey that is affiliated with an insurance company, hospital service corporation or medical service corporation shall treat the health maintenance organization as a separate carrier.

"Board" means the Board of Directors of the New Jersey Small Employer Health Benefits Program established by the Act.

"Carrier" means any insurance company, health service corporation, hospital service corporation, medical service corporation, or health maintenance organization authorized to issue health benefits plans in New Jersey.

"Cash deductible" means the amount of covered charges that a covered person must pay before the policy pays any benefits for such charges.

"Co-insurance" means the percentage of a covered charge that must be paid by a covered person. Co-insurance does not include cash deductibles, co-payments or non-covered charges.

"Co-insured charge limit" means the amount of covered charges a covered person must incur before no co-insurance is required with the following exception. Charges for mental and nervous conditions and substance abuse treatment are not subject to or eligible for the co-insured charge limit.

"Co-payment" means a specified dollar amount a covered person must pay for specified covered charges.

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

"Department" means the New Jersey Department of Insurance.

"Dependent" means the spouse or child of an eligible employee subject to applicable terms of the employee's health benefits plan.

"Doctor" means a medical practitioner who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and

2. Provides medical services which are within the scope of the practitioner's license or certificate and which are covered by policies provided pursuant to this chapter.

"Eligible employee" means a full-time employee who works a normal work week of 25 or more hours. The term includes a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefits plan of a small employer, but does not include employees who work less than 25 hours a week or work on a temporary or substitute basis.

"Federally-qualified HMO" is a health maintenance organization which is qualified pursuant to the Health Maintenance Organization Act of 1973, Pub. L. 93-222 (42 U.S.C. §300e et seq.)

"Health benefits plan" means any hospital and medical expense insurance policy or certificate; health, hospital, or medical service corporation contract or certificate; or health maintenance organization subscriber contract or certificate delivered or issued for delivery in this State by any carrier to a small employer group pursuant to section 3 of the Act (N.J.S.A. 17B:27A-19). For purposes of this act, "health benefits plan" excludes the following plans, policies, or contracts: accident only, credit, disability, long-term care, coverage for Medicare services pursuant to a contract with the United States government, Medicare supplement, dental only or vision only, in-

surance issued as a supplement to liability insurance, coverage arising out of a workers' compensation or similar law, automobile medical payment insurance, or personal injury protection coverage issued pursuant to P.L. 1972, c.70 (N.J.S.A. 39:6A-1 et seq.).

"Late enrollee" means an eligible employee or dependent who requests enrollment in a health benefits plan of a small employer following the initial minimum 30-day enrollment period provided under the terms of the health benefits plan. An eligible employee or dependent shall not be considered a late enrollee if the individual: was covered under another employer's health benefits plan at the time he was eligible to enroll and stated at the time of the initial enrollment that coverage under that other employer's health benefits plan was the reason for declining enrollment; has lost coverage under that other employer's health benefits plan as a result of termination of employment, the termination of the other plan's coverage, death of a spouse, or divorce; and requests enrollment within 90 days after termination of coverage provided under another employer's health benefits plan. An eligible employee or dependent also shall not be considered a late enrollee if the individual is employed by an employer which offers multiple health benefits plans and the individual elects a different plan during an open enrollment period; or if a court of competent jurisdiction has ordered coverage to be provided for a spouse or minor child under a covered employee's health benefits plan and request for enrollment is made within 30 days after issuance of that court order.

"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.

"Medicare" means coverage provided pursuant to Title XVIII of the Federal Social Security Act, Pub. L. 89-97 (42 U.S.C. §1395 et seq.) and amendments thereto.

"Multiple employer arrangement" means an arrangement established or maintained to provide health benefits to employees and their dependents of two or more employers, whether fully insured or not fully insured, and shall include, but is not limited to, a multiple employer welfare arrangement, or MEWA, multiple employer trust or other form of benefit trust.

"Member" means a carrier that issues health benefits plans in New Jersey on or after November 30, 1992.

"Pre-existing condition" means a policy or contract provision that excludes coverage under that policy or contract for charges or expenses incurred during a specified period following the insured's effective date of coverage, for a condition that, during a specified period immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received as to that condition or as to pregnancy existing on the effective date of coverage.

"Primary care *[physician]* ***practitioner***" means a network, or participating, provider who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology for those services only if applicable, or pediatrics, who supervises, coordinates, arranges and provides initial care and basic care medical services to a member; initiates a member's referral for specialist services; and is responsible for maintaining continuity of patient care.

"Program" means the New Jersey Small Employer Health Benefits Program established pursuant to the Act.

"Small employer" means any person, firm, corporation, partnership, or association actively engaged in business which, on at least 50 percent of its working days during the preceding calendar year quarter, employed at least two but no more than 49 eligible employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible employees, companies which are affiliated companies shall be considered one employer. Subsequent to the issuance of a health benefits plan to a small employer pursuant to the provisions of the Act and this chapter, and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, provisions of the Act and this chapter which apply to a small employer shall continue to apply until the anniversary date of the health benefits plan next following the date the employer no longer meets the definition of a small employer.

"Small employer carrier" means any carrier that offers health benefits plans covering eligible employees of one or more small employers.

"Small employer health benefits plan" means a health benefits plan for small employers approved by the Commissioner pursuant to section 17 of P.L. 1992, c.162 (N.J.S.A. 17B:27A-33).

"State approved HMO" is a health maintenance organization which is approved pursuant to P.L. 1973 c.337 (N.J.S.A. 26:2J-1 et seq.).

SUBCHAPTER 2. (RESERVED)

SUBCHAPTER 3. STANDARD BENEFIT PLANS AND RIDERS

11:21-3.1 Benefits provided

(a) The small employer health benefits plans established by the Board contain the benefits, limitations and exclusions set forth in the Appendix to this chapter which is incorporated herein by reference as follows:

1. Plan A, "The Small Group Health Benefits Basic Policy," Exhibit A;
2. Plan B, "The Small Group Health Benefits Policy B," Exhibit B and Exhibit F;
3. Plan C, "The Small Group Health Benefits Policy C," Exhibit C and Exhibit F;
4. Plan D, "The Small Group Health Benefits Policy D," Exhibit D and Exhibit F;
5. Plan E, "The Small Group Health Benefits Policy E," Exhibit E and Exhibit F;
6. Exhibit F contains those terms of Plans B, C, D and E which are common among the plans; and
7. HMO Plan, "The Small Group Health Maintenance Organization Contract," Exhibit G.

(b) In accordance with this chapter, members that offer small employer health benefits plans in this State shall only offer all of the health benefits Plans A, B, C, D, and E as set forth in Exhibits A through F, in the Appendix, except as set forth in (c) below.

1. Plans B, C and D shall contain the following annual deductible options to the small employer for each plan:

i. $250.00 per covered person and $500.00 per covered family. The family deductible limit must be satisfied by two separate covered persons;

ii. $500.00 per covered person and $1,000 per covered family. The family deductible limit must be satisfied by two separate covered persons; and

iii. $1,000 per covered person and $2,000 per covered family. The family deductible limit must be satisfied by two separate covered persons.

2. Members offering Plan E shall offer only an annual deductible of $150.00 per covered person and $300.00 per covered family. The family deductible limit must be satisified by two separate covered persons.

(c) State approved and Federally qualified HMO members may offer the HMO Plan, as set forth in Exhibit G of the Appendix, in lieu of Plans A through E in (a) above. HMO members offering the HMO Plan shall offer the following arrangements: $150.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $15.00 co-payment for all other co-payments. Prescription drugs may be subject to 50 percent coinsurance or $15.00 co-payment at HMO member's option. HMO members choosing to offer optional health benefits plans may offer one or more of the following co-payment options, provided that all options offered by the HMO member shall be offered to each small employer:

1. $75.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $5.00 co-payment for all other co-payments;
2. $100.00 hospital inpatient co-payment, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $10.00 co-payment for all other co-payments; and/or
3. $250.00 hospital inpatient co-payment excluding mental/nervous ***and*** substance abuse *[and alcoholism treatment]*, $200.00 mental/nervous and substance abuse hospital inpatient co-payment *[and alcoholism hospital inpatient co-payment]*, $50.00 separate emergency room co-payment, $25.00 pre-natal care office visit co-payment (initial visit only) and $20.00 co-payment for all other co-payments.

(d) The small employer health benefits Plans B, C, D and E and the HMO Plan and optional riders may be offered through or in conjunction with an approved contracting arrangement approved pursuant to P.L. 1993, c.162, Section 22, and shall be subject to the following:

1. The in-network and out-network benefit level differential shall not exceed 30 percent;
2. The co-insured charge limit and deductibles specified for the standard health benefits plan being offered through or in conjunction with a managed care arrangement, as set forth in Exhibits B through G in the Appendix, shall be the co-insured charge limit and deductibles for the in-network and out-network benefits combined;
3. The HMO Plan standard co-payment levels for practitioner visits, emergency room and hospital confinements may be substituted for deductibles applicable to in-network benefits and out-network benefits. Where such co-payments are utilized, the applicable deductible and co-insured charge limit shall be applicable only to out-network benefits; and
4. Where in-network services are directed through a primary care physician under Plans B, C, D and E and HMO Plan, in-network services must conform to one of the options provided in (c) above, and out-network services must conform to one of the options provided in (b) above.

(e) The small employer health benefits Plan A may be offered through or in conjunction with a managed care arrangement, and shall be subject to the following:

1. For those services which are subject to 20 percent co-insurance, the in-network benefit shall not be subject to co-insurance; and
2. For those services which are subject to 50 percent co-insurance, the in-network co-insurance shall be 30 percent.

11:21-3.2 Optional benefit riders

(a) Members that offer health benefits Plans B, C, D and E may offer one or more of the optional benefit riders set forth in (c)1 and 2 below. Members that offer the HMO health benefits plan may offer the prescription drug riders set forth in (c)3 below. All riders shall contain the benefits, limitations and exclusions set forth in the Appendix which is incorporated herein by reference and shall be issued in the standard form set forth in the Appendix which is incorporated herein by reference. A member electing to offer an optional benefits rider with a health benefits plan (Plan B, C, D, E or HMO Plan, as applicable) must offer the rider to any employer seeking to purchase that health benefits plan.

(b) Any member electing to offer one or more optional benefits riders shall file a statement identifying the rider(s) to be offered and identifying the health benefits plan(s) with which the rider will be offered. The statement shall be filed with the Board no later than 30 days prior to the date the rider is to be offered to employers, and shall set forth the date on which the carrier proposes to offer such rider(s).

(c) The optional benefit riders are as follows:

1. Replacement prescription drug benefits for Plans B, C, D and E. The carrier may select one or more of the following riders to be offered with each health benefits Plan (Plan B, C, D, or E):
   i. Exhibit H, part 1 (mail order and card);
   ii. Exhibit H, part 2 (card only); or
   iii. Exhibit H, part 3 (mail order only)
2. Replacement mental and nervous conditions and substance abuse benefits, Exhibit I; and
3. Replacement prescription drug benefits for HMO Plans. The carrier may select one or more of the following riders to be offered with the HMO health benefits plan:
   i. Exhibit J, part 1 (mail order and card);
   ii. Exhibit J, part 2 (card only); or
   iii. Exhibit J, part 3 (mail order only).

SUBCHAPTER 4. POLICY FORMS

11:21-4.1 Policy forms

(a) Members shall use the standard policy forms for Plans A, B, C, D and E which are set forth in the Appendix to this chapter as Exhibits A through F, subject to the "Explanation of Brackets (Plans A, B, C, D)" set forth in Exhibit K, Part 1 of the Appendix, incorporated herein by reference.

(b) Members shall use the standard policy form for HMO Plan which is set forth in the Appendix to this chapter as Exhibit G, subject to the "Explanation of Brackets (HMO Plan)" set forth in Exhibit K, Part 2 of the Appendix, incorporated herein by reference.

(c) In issuing riders pursuant to N.J.A.C. 11:21-3, members shall use the standard rider forms which are set forth in the Appendix to this chapter as Exhibits H, I and J, as applicable.

(d) All health benefits plans and optional benefits riders issued to small employers on and after January 1, 1994 shall be issued in accordance with these rules.

SUBCHAPTER 5. STANDARD CLAIM FORM

11:21-5.1 Standard Claim Form

(a) All members offering health benefits plans to small employers shall, to the extent that the member uses claims forms in its transaction of business, require as a condition of payment, the standard claim form approved by the Board and set forth as Exhibit L in the Appendix to this chapter, incorporated herein by reference. The HCFA 1500 form and patient instructions, set forth in Exhibit L, Part 1, shall be the standard claim form for all medical expenses incurred for services other than hospital inpatient services. The form UB-82 set forth as Exhibit L, Part 2, shall be the standard claim form for all hospital inpatient services.

(b) If a carrier determines that additional information is necessary of the claimant to process a claim, the carrier shall use the "Annual Family Profile and Claim Notice" form as set forth as Exhibit M and incorporated herein by reference. A carrier shall not use any other form to solicit family profile information of the claimant.

SUBCHAPTERS 6-18. (RESERVED)

APPENDIX

EXHIBIT A

PLAN A
[Carrier]

SMALL GROUP HEALTH BENEFITS BASIC POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF POLICY
[January 1, 1994]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy. The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

POLICY INDEX

SECTION	PAGE(S)
Schedule of Insurance and Premium Rates	
General Provisions	
Claims Provisions	
Planholders	
Definitions	
Employee Coverage	
Dependent Coverage	
Preferred Provider Organization Provisions	
Point of Service Provisions	
Health Benefits Insurance	
Utilization Review Features	
Alternate Treatment Features	
Centers of Excellence Features	
Exclusions	
Continuation Rights	
Conversion Rights for Divorced Spouses	
Effect Of Interaction with a Health Maintenance Organization Plan	
Coordination of Benefits	
Benefits for Automobile Related Injuries	
[How This Policy Interacts with] Medicare ***as Secondary Payor***	
Right To Recovery—Third Party Liability	
Statement of ERISA Rights	
Claims Procedures	

SCHEDULE OF INSURANCE AND PREMIUM RATES PLAN A

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• for Preventive Care	None
• for Facility charges made by:	
—a Hospital	20%
—an Ambulatory Surgical Center	20%
—a Birthing Center	20%
—an Extended Care Center or Rehabilitation Center	20%
—a Hospice	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:	
—Prescription Drugs	20%
—Blood Transfusions	20%
—Infusion Therapy	20%
—Chemotherapy	20%
—Radiation Therapy	20%
• for all other Covered Charges	50%
Co-Insurance Cap per Covered Person per each Calendar Year	$5,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE: PLAN A PPO

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible:

• for Hospital Confinement	None (Note: See Hospital Confinement Co-Payment)
• for Preventive Care	None
• for All Other Charges	
—per Covered Person	$250
—per Covered Family	$500. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$250
—maximum Co-Payment per Period of Confinement	$1,250
—maximum Co-Payment per Covered Person per Calendar Year	$2,500

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

	If treatment, services or supplies are given by *[a]*:	
	***a* Network Provider**	***an* *[Non-]* *Out-* Network Provider**
The **Co-Insurance** for this Policy is as follows:		
• for Preventive Care	None	None
• for Facility charges made by:		
—a Hospital	None	20%
—an Ambulatory Surgical Center	None	20%
—a Birthing Center	None	20%
—an Extended Care Center or Rehabilitation Center	None	20%
—a Hospice	None	20%
• for the following Covered Charges incurred while the Covered Person is an Inpatient in a Hospital:		
—Prescription Drugs	None	20%
—Blood Transfusions	None	20%
—Infusion Therapy	None	20%
—Chemotherapy	None	20%
—Radiation Therapy	None	20%
• for all other Covered Charges	70%	50%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Coinsurance is required.

Coinsured Charge Limit: $10,000

Daily Room and Board Limits

• During a Period of Hospital Confinement

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• During a Confinement In An Extended Care Center Or Rehabilitation Center

[Carrier] will cover the lessor of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient Hospital confinement	30 days
Charges for Home Health Care	exchange basis* for Hospital days
Charges for Extended Care or Rehabilitation Center Care	exchange basis* for Hospital days
Charges for Hospice Care	exchange basis* for Hospital days

*See the **Covered Charges** section for a description of the exchange rules.

Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	
—per Covered Person	$100
—per Covered Family	$300
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

PREMIUM RATES

[The ***initial*** monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	**Premium Rate**
Health Benefits	
—per Employee	$9999.99
—per Employee and spouse	$9999.99
—per Employee and children	$9999.99
—per Employee, spouse and children	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;
b.] the Policyholder's application, a copy of which is attached to this Policy;
[c.] any riders, [endorsements] or amendments to this Policy and
[d.] the individual applications, if any, of the persons covered.

STATEMENTS

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or

b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years ***from the Effective Date***.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[If this Policy replaces the policy of another insurer, [Carrier] may rescind this Policy based on misrepresentations made in the Policyholder's or a Covered Person's signed application for up to two years from this Policy's Effective Date.]

AMENDMENT

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

[d.] In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

AFFILIATED COMPANIES

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees ***and Dependents*** then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee ***and/or Dependent*** whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's ***and/or Dependent's*** coverage has ended.

b. The amount of any claims paid to an Employee for the Employee's claims or to a member of the Employee's family unit after that person's coverage has ended.]

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the *[first]* time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date are shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.

b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.

c. Any date that the extent or nature of the risk under this Policy is changed:

- by amendment or this Policy; or
- by reason of any provision of law or any government program or regulation; or
- if this Policy supplements or coordinates with benefits provided by another insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.

d. At the discovery of a clerical error or misstatement as described below.

e. As of the date the nature of the Policyholder's business changes.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or

b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or
b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

CLERICAL ERROR—MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will ***not*** invalidate coverage ***which would*** otherwise ***be in force, or continue coverage which would otherwise be*** validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverge is in force under the terms of this Policy, and in what amounts.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. ***The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.***

[b. the Policyholder moves its principal place of business outside the State of New Jersey;]

*[c.]***b.*** subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;

*[d.]***c.*** with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

*[e.]***d.*** with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Policy is issued for a term of one (1) year from the Effective Date shown on the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer ***in accordance with the laws in the State of New Jersey***.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the actions described above as of the Employer's Policy Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify [Carrier] within 30 days. [Carrier] has the right to change the rates [Carrier] charges for this Policy if this happens. If the Employer fails to notify [Carrier] within 30 days, [Carrier] has the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,
(2) any protection and rights when the coverage ends and
(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS—INFORMATION TO BE FURNISHED

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee and Dependents eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee or Dependent coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage *[has]* ***should have*** ended.]

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

[When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [Carrier] may honor such direction at [Carrier's] option. The Employee may not assign his or her right to take legal action under this Policy to such provider.]

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

[An Employee] ***A Covered Person*** cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and
d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. ***Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges.*** See the **The Cash Deductible** section of this Policy for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of this Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while he or she is insured by this Policy. Read *[the]* ***this*** entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an eligible Employee or a Dependent who is insured under this Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means an Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. *[his or her]* unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

***Dependent's Eligibility Date means the later of:**

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.*

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Coverage Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which ***is***:

a. *[is]* designed and able to withstand repeated use;
b. *[is]* primarily and customarily used to serve a medical purpose;
c. *[is]* generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. *[is]* suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee or Dependent, as the context in which the term is used suggests.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. ***Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of this Policy.***

***Employee's Eligibility Date means the later of:**

a. the date of employment; or
b. the day after any applicable waiting period ends.*

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

*[Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;]*
b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined in item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:
a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and
b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which *[mainly]* provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a *[Facility]* ***Provider*** which *[mainly]* provides palliative and supportive care for terminally ill ***or terminally injured*** people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. approved for its stated purpose by Medicare; or
b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:
a. accredited as a Hospital by the Joint Commission or
b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under this Policy more than ***[*30*]*** days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:
a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;
c. in accordance with ***generally*** accepted medical *[standards in the community at the time]* ***practice***;
d. not for the convenience of a Covered Person;
e. the most appropriate level of medical care the Covered Person needs;
[f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and]
*[g.]***f.*** furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the ***United States*** Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the ***United States*** Social Security Act, as amended from time to time.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption ***of coverage***.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

*[[**Note:** This definition is needed only for Plan B.]]*

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased ***this*** group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

Podiatric Care means treatment of Illness or deformity below the ankle, but does not include dislocations or fractures of the foot.

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

*[**Reasonable and Customary** means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.]*

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot stain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the ***appropriate*** nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in this Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center).

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;
b. cardiac care units;
c. neonatal care units; and
d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other ***invasive*** procedures;
b. the correction of fractures and dislocations;
c. Reasonable and Customary pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the inpingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[**We, Us, Our** and [**Carrier**] mean [Carrier].]

[**You, Your and Yours** mean the Employer.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligiblity** set forth below, and to all of the other conditions of *[the]* ***this*** Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet *[the]* ***this*** Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[If an Employee must pay part of the cost of Employee Coverage,] [Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments***, if any. If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.***

If the Employee *[does this]* ***enrolls and agrees to make the required payments, if any***:

a. more than ***[*30*]*** days after the *[Employee first becomes eligible]* ***Employee's Eligibility Date***; or

b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;

b. divorce;

c. death of the Employee's spouse; or

d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Policy has the following waiting periods:

*[Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service with the Employer.]]*

Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

*[The scheduled Effective Date of an Employee's coverage is as follows:

a. If an Employee must pay part of the cost of Employee coverage, then he or she]* ***The Employee*** must elect to enroll and agree to make the required payments***, if any,*** within ***[*30*]*** days of *[his or her]* ***the Employee's*** Eligibility Date. If he or she does this within ***[*30*]*** days of *[his or her]* ***the Employee's*** Eligibility Date, his or her coverage is scheduled to start on *[his or her]* ***the Employee's*** Eligibility Date. ***Such Employee's Eligibility Date is the scheduled Effective Date of an Employee's coverage.***

[b. On non-contributory plans, subject of all the terms of this plan, an Employee's coverage starts on his or her eligibility date.]

When Employee Coverage Ends

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.

b. [the date] an Employee stops being an eligible Employee under this Policy.

c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.

d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are ***the Employee's***:

a. *[the Employee's]* legal spouse;

b. *[the Employee's]* unmarried Dependent children who are under age 19; and

c. *[the Employee's]* unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or

b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children,

b. his or her step-children if such step-children depend on the Employee for most of their support and maintenance, and

c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and *[the plan]* ***this Policy***, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Policy's age limit;

b. the child became insured by this Policy ***or any other policy*** before the child reached the age limit, and stayed continuously insured *[until]* ***after*** reaching such limit; and
c. the child depends on the Employee for most of *[their]* ***his or her*** support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent and agrees to make the required payments *[after the end of the enrollment period]* ***more than [30] days after the Dependent's Eligibility Date***;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy ***and stated at that time that such waiver was*** because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. ***Coverage will take effect as of the date one of the above events occurs.***

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date *[he or she becomes eligible]* ***required pursuant to a court order***.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent Coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this *[on or before the Employee's]* ***within [30] days of the Dependent's*** Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the *[Employee's]* ***Dependent's*** Eligibility Date, or
b. the date the Employee becomes insured for Employee coverage.

If the Employee does this *[within or after the enrollment period, the]* ***more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee***. Coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within *[the enrollment period]* ***[30] days after the Dependent's Eligibility Date***. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:

a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the *[date]* ***Dependent's Eligibility Date*** for the Newly Acquired Dependent *[is first eligible]*.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under this Policy will end on the first of the following dates:

a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. ***at 12:01 a.m. on*** the date the Dependent stops being an eligible Dependent. *[This happens at 12:01 a.m. on the date:
   - the child attains the Policy's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.]*

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer, XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and sup-

plies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card].

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of *[Practitioners]* ***PCPs*** who are members of the [XYZ] Provider Organization to the Covered Person.

b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.

c. ***Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.

d. ***Out-Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.

e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care *[Physician]* *Practitioner* (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she *[will not]* ***may only*** be eligible for ***Out-***Network Benefits.

[Carrier] *[pays]* ***provides*** Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP, ***the Covered Person may only be eligible for*** Out-Network Benefits *[will be provided]*.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, ***the Covered Person may only be eligible for*** Out-Network Benefits *[will be paid]*.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room vists to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the ***PO*** Service Area *[of the EPO]*.

Utilization Review

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is issued as POS.]

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or eliminated if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

Family Deductible Limit

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

Co-Insurance Cap

This Policy limits Co-Insurance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;

b. Cash Deductibles; and

c. Co-Payments.

There is Co-Insurance Cap for each Covered Person.

The Co-Insurance Cap is shown in the Schedule.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by 2 or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the ***[How This Policy Interacts With]* Medicare *as Secondary Payor*** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

Extended Health Benefits

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:

a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Charges while Hospitalized

[Carrier] covers charges incurred while a Covered Person is an Inpatient in a Hospital up to 30 days per Covered Person per Calendar Year. Covered Charges are as follows:

a. Hospital room and board
b. Routine Nursing Care
c. Prescription Drugs
d. Blood transfusions
e. Infusion Therapy
f. Chemotherapy
g. Radiation Therapy
h. Medically Necessary and Appropriate Hospital services and supplies provided to the Covered Person during the Inpatient confinement.

[Carrier] limits what it pays for each day to the room and board limit shown in the Schedule.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services*[, including services provided by a Hospital Outpatient clinic]*.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

Note: [Carrier] covers charges for Inpatient Hospital care up to 30 days per Covered Person per Calendar Year. Such 30 Inpatient days may be exchanged for other types of care, as explained in the **Extended Care *[and]* *or* Rehabilitation Charges, Home Health Care Charges** and **Hospice Charges** sections.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $250 Co-Payment for each day of confinement, up to a maximum of $1,250 per *[confinement]* ***Period of Confinement***, subject to a maximum $2,500 Co-Payment per Calendar Year.

Testing Charges

[Carrier] covers x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

X-ray and laboratory tests which are not performed in connection with a planned Hospital admission or Surgery are Non-Covered Charges.

Extended Care *[and]* *or* Rehabilitation Charges

Subject to [Carrier's] Pre-Approval, when Extended Care and Rehabilitation care can take the place of Inpatient Hospital care, [Carrier] covers such care provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Each 2 days of Extended Care and Rehabilitation Charges will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. *[start within 2 days of a Hospital stay; and]* ***(Reserved)***
b. be due to the same or a related condition that necessitated the Hospital stay.

Extended Care *[and]* *or* Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges

Subject to [Carrier's] Pre-Approval, when Home Health Care can take the place of Inpatient Hospital care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. Each 2 days of Home Health Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:
    a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.

b. The services and supplies must be:
- ordered by the Covered Person's Practitioner;
- included in the home health care plan; and
- furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.

d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.

e. [Carrier] does not pay for:
- services furnished to family members, other than the patient; or
- services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury ***which are incurred while the Covered Person is an Inpatient in a Hospital***.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;

b. are not business associates of the Practitioner who recommended the Surgery; and

c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, when Hospice Care can take the place of Inpatient Hospital Care, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill ***or terminally injured*** Covered Person under a Hospice care program. Each 2 days of Hospice Care will reduce the number of Inpatient Hospital days available to a Covered Person by 1 day.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness ***or terminal Injury***.

"Terminally ill" ***or "terminally injured"*** means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill ***or terminally injured*** Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;

b. ordered by the Covered Person's Practitioner;

c. included in the Hospice care program; and

d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;

b. funeral services and arrangements;

c. legal or financial counseling or services; or

d. treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Pregnancy

This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a. nursery charges;

b. charges for routine Practitioner's examinations and tests; and

c. charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics

[Carrier] covers anesthetics and their administration.

COVERED CHARGES WITH SPECIAL LIMITATIONS

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any *[*30*]* day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee. *The "Pre-existing Conditions" provision does not apply to a Dependent who is an adopted child or who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.*

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition

was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below when provided on either an Inpatient or on an Outpatient basis.

a. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

b. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

[Carrier] covers the therapy Services listed below but **only** when provided on an Inpatient basis.

c. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

d. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

e. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery*[, congenital anomaly]* or previous therapeutic process ***; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly***.

f. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

g. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

h. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverage*[s]* for Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per Calendar Year.

i. *Infusion Therapy*—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to $100 per Covered Person $300 per Covered Family.

***[IMPORTANT NOTICE**

This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's Office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or

b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.

This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.

What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;

b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals.]

REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practi-

tioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission
b. the anticipated length of stay and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person, or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges, **by 50%** if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges **by 50%**, if:

a. [ABC] is not notified of the admission at the times and in the manner described above; or
b. the Covered Person does not request a continued stay review.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.

REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person, or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%** if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d. [ABC] does not confirm the need for Surgery.

But there is no penalty when the additional opinions do not confirm the need for the Surgery, and the Surgery is done anyway.

Penalties cannot be used to meet this Policy's:
a. Cash Deductible; or
b. Co-Insurance Caps.

ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:
a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefit for charges incurred for the services and supplies would not otherwise by payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:
a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:
a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes;
a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and per lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.

CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:
a. perform a Pre-Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]*

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Care or treatment of ***alcohol abuse.***

Services for ***ambulance*** for transportation.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an ***Illness or*** Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances.

Charges made by a ***dialysis center*** for dialysis services.

Durable Medical Equipment

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Care or treatment in an ***emergency room*** unless the Covered Person is admitted within 24 hours.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:
a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lense; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids *and* hearing *[examinations*** or fitting of]* ***exams*** **to determine the need for*** hearing aids ***or the need to adjust them*.**

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy.***

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Care and treatment for ***Mental and Nervous Conditions and Substance Abuse.***

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Podiatric care.

Practitioner visits, except as ****otherwise**** stated in *[the Preventive Care section of]* this Policy.

Prescription Drugs obtained while not confined in a Hospital on an Inpatient basis.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

Prosthetic Devices.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in this Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Therapeutic Manipulation.

Transplants.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** delcared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug ****if such drug is**** used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's *[plan]* *Policy*. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, *[and therefore]* *in which case*;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Poilcy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the ***United States*** Social Security Act on the date

his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the *[Employee]* ***qualified continuee*** by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. The Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Policy's group health benefits;
b. The monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualfied continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. The Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. The Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the ***United States*** Social Security Act;
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

***[Important Notice**

This section applies only to group health benefits. This section does not apply to any other coverages provided by this Policy.]*

If An Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group *[medical]* ***health benefits*** plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person.
e. with respect to a Covered Person who becomes covered under another group *[medical]* ***health benefits*** plan which contains a limitation or exclusion with respect to a Pre-Existing condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying;
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's *[plan]* *Policy*. The Employee must contact his or her Employer to find out if:

- **the Employer must allow for a leave of absence under Federal law *[and, therefore]* *in which case*;**
- **the section applies to the Employee.**

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her *[medical care]* ***group health benefits*** insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-Time work;
b. the end of a total ***leave*** period of 12 weeks in any 12 month period; *[or]*
c. the date on which the Employee's coverage would have ended had the Employee not been on leave; ***or***
***d. the end of the period for which the premium has been paid*.**

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health *[coverage]* ***benefits*** for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health *[coverage]* ***benefits*** ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

[a. unless he or she has been insured under this Policy for at least 3 months;]

*[b.]***a.*** if he or she is eligible for Medicare; or

*[c.]***b.*** if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health *[coverage]* ***benefits*** ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health *[coverage]* ***benefits*** under this Policy ends.

After group health *[coverage]* ***benefits*** under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the *[medical care benefits]* ***group health benefits insurance*** provided by this Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date *[Medical Care]* *Group Health Benefits* Insurance Ends

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After *[Medical Care]* *Group Health Benefits* Insurance Ends

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:

IF, on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN *[medical care]* ***group health*** benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS *[MEDICAL CARE]* *GROUP HEALTH BENEFITS* INSURANCE PROVIDED BY THIS POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made at any other time

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will *[not]* be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in this Policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

***[Important Notice**

This provision applies to all health expense benefits under this Policy. It does not apply to death, dismemberment, or loss of income benefits.]*

Purpose Of This Provision

[An Employee] ***A Covered Person*** may be covered for health expense benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
*[e. group or group-type hospital indemnity benefits which exceed $150.00 per day.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordiante with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $150.00 per day or less; and]*
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.
   - When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
   - If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
   - The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right to Certain Information

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or gets information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFIT FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Covered Person as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian; caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not

themselves named insureds under another automobile policy. This Policy may be primary for one Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

Medicare

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

[HOW THIS POLICY INTERACTS WITH]* MEDICARE *AS SECONDARY PAYOR

IMPORTANT NOTICE

***[The following section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer is subject to the How This Plan Interacts with Medicare section and therefore;**
- **this section applies to the Employee]***

***The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.**

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.*

The following provisions explain how this *[plan's]* ***Policy's*** group health benefits interact with the benefits available under Medicare ***as Secondary Payor rules***. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as *[shown]* ***explained*** below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the ***United States*** Social Security Act, as amended from time to time.
b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.
c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense."

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible".

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse
b. an Employee or insured spouse who is under age 65, or
c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option (A)—The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option B—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary

When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and
b. eligible for Medicare by reason of *[End Stage Renal Disease]* ***disability***.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or
b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When a Covered Person Becomes Eligible for Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, ***Medicare is the primary plan***. This Policy *[supplements the benefit provided by Medicare]* ***is the secondary plan***.

[If the disabled Medicare incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, [Carrier] subtracts what Medicare pays from what [Carrier] normally pays.]

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare *[solely]* on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as an "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When a Covered Person Becomes Eligible for Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to an ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, *[[Carrier] supplements what]* Medicare *[pays]* ***is the primary plan. This Policy is the secondary plan.*** *[[Carrier] subtracts what Medicare pays from what [Carrier] normally pays.]* If a Covered Person is eligible for Medicare *[solely]* on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers, fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier] However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or

b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA), ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.

b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.

c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employee's claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contract the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.

b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.

c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:

- the specific reason(s) the claim is denied;
- specific references to the pertinent plan provision on which the denial is based;
- a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
- and explanation of the plan's claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision

as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT B

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN B]

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
—**Emergency Room Co-Payment,** (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:	40%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$3,000
Per Covered Family per each Calendar Year	$6,000. **Note:** Must be individually satisfied by 2 separate Covered Persons

***Note: The Co-Insurance Caps cannot be met with:**

- **Non-Covered Charges**
- **Cash Deductibles**
- **Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Co-Payments.***

Daily Room and Board Limits

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for ***therapeutic*** manipulation *[or adjustment of the spine,]* per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	$1,000,000

*...

DEFINITIONS [PLAN B]

...

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

...*

*...

HEALTH BENEFITS INSURANCE [PLAN B]

...

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co-Payment Requirement section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co-Payment for each day of confinement, up to a maximum of $1,000 per Period of Confinement, subject to a maximum $2,000 Co-Payment per Calendar Year.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

...*

EXHIBIT C

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN C]

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:	30%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,500
Per Covered Family per each Calendar Year	$5,000 **Note:** Must be individually satisfied by 2 separate Covered Persons

***Note: The Co-Insurance Caps cannot be met with:**

- **Non-Covered Charges**
- **Cash Deductibles**
- **Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Co-Payments.***

Daily Room and Board Limits ***[PLANS C, D, E]***

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for ***therapeutic*** manipulation *[or adjustment of the spine]* per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year as follows: (Not subject to Cash Deductible or Co-Insurance)	
• for a Covered person who is a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1	$500 per Covered Person
• for all other Covered Persons	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

*...

DEFINITIONS [PLANS C, D, E]

...

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

...*

*...

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

...

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co-Payment Requirement section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

...*

EXHIBIT D

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN D]

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	25%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$2,000
Per Covered Family per each Calendar Year	$4,000. **Note:** Must be individually satisfied by 2 separate Covered Persons

***Note: The Co-Insurance Caps cannot be met with:**

- **Non-Covered Charges**
- **Cash Deductibles**
- **Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Co-Payments.***

Daily Room and Board Limits ***[PLANS C, D, E]***

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80% of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

- **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or
b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for ***therapeutic*** manipulation *[or adjustment of the spine]* per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

*...

DEFINITIONS [PLANS C, D, E]

...

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

...*

***...**

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

...

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co-Payment Requirement section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

...*

EXHIBIT E

SCHEDULE OF INSURANCE AND PREMIUM RATES [PLAN E]

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	$150
Per Covered Family	$300. Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:	10%

Co-Insurance Caps

Per Covered Person per each Calendar Year	$1,500
Per Covered Family per each Calendar Year	$3,000 **Note:** Must be individually satisfied by 2 separate Covered Persons

***Note: The Co-Insurance Caps cannot be met with:**

- **Non-Covered Charges**
- **Cash Deductibles**
- **Co-Insurance for the treatment of Mental and Nervous Conditions and Substance Abuse**
- **Co-Payments.***

Daily Room and Board Limits ***[PLANS C, D, E]***

- **During a Period of Hospital Confinement**

For semi-private room and board accommodations, [Carrier] will cover charges up to the Hospital's actual daily semi-private room and board rate.

For private room and board accommodations, [Carrier] will cover charges up to the Hospital's average daily semi-private room and board rate, or if the Hospital does not have semi-private accommodations, 80%

of its lowest daily room and board rate. However, if the Covered Person is being isolated in a private room because the Covered Person has a communicable illness, [Carrier] will cover charges up to the Hospital's actual private room charge.

For Special Care Units, [Carrier] will cover charges up to the Hospital's actual daily room and board charge.

• **During a Confinement In An Extended Care Center Or Rehabilitation Center**

[Carrier] will cover the lesser of:

a. the center's actual daily room and board charge; or

b. 50% of the covered daily room and board charge made by the Hospital during the Covered Person's preceding Hospital confinement, for semi-private accommodations.

Pre-Approval is required for charges incurred in connection with:

- Durable Medical Equipment
- Extended Care and Rehabilitation
- Home Health Care
- Hospice Care
- Infusion Therapy
- Prosthetic Devices

Charges which are not Pre-Approved by [Carrier] are Non-Covered Charges

Payment Limits: For Illness or Injury, [Carrier] will pay up to the payment limit shown below:

Charges for Inpatient confinement in an Extended Care or Rehabilitation Center, per Calendar Year (Combined benefits)	120 days
Charges for ***therapeutic*** manipulation *[or adjustment of the spine]* per Calendar Year	30 visits
Charges for speech and cognitive therapy per Calendar Year (combined benefits)	30 visits
Charges for physical or occupational therapy per Calendar Year (combined benefits)	30 visits
Charges for Preventive Care per Calendar Year (Not subject to Cash Deductible or Co-Insurance)	$300 per Covered Person
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, per Calendar Year	$5,000
Charges for all treatment for Mental and Nervous Conditions and Substance Abuse, Per Lifetime	$25,000
Per Lifetime Maximum Benefit (for all Illnesses and Injuries)	Unlimited

*...

DEFINITIONS [PLANS C, D, E]

...

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and

b. with or without interruption of coverage.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan"]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder"]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and

b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

...*

*...

HEALTH BENEFITS INSURANCE [PLANS C, D, E]

...

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's Emergency Room Co-Payment Requirement section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the Charges Covered with Special Limitations section of this Policy.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

...*

EXHIBIT F

PLANS B, C, D, E
[Carrier]

SMALL GROUP HEALTH BENEFITS POLICY

POLICYHOLDER: [ABC Company]

GROUP POLICY NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF POLICY
[January 1, 1994]

POLICY ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier] in consideration of the application for this Policy and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Policy. This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Policy. The Effective Date is specified above.

This Policy takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in the **General Provisions** section.

[Secretary President]

[Dividends are apportioned each year.]

POLICY INDEX

SECTION	PAGE(S)
Schedule of Insurance and Premium Rates	
General Provisions	
Claim Provisions	
Planholders	
Definitions	
Employee Coverage	
Dependent Coverage	
Preferred Provider Organization Provisions	
Point of Service Provisions	
Health Benefits Insurance	
Utilization Review Features	
Alternate Treatment Features	
Centers of Excellence Features	
Exclusions	
Continuation Rights	
Conversion Rights for Divorced Spouses	
Effect Of Interaction with a Health Maintenance Organization Plan	
Coordination of Benefits	
Benefits for Automobile Related Injuries	
[How This Policy Interacts with] Medicare **as Secondary Payor***	
Right To Recovery—Third Party Liability	
Statement of ERISA Rights	
Claims Procedures	

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (without Co-payment)**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Calendar Year Cash Deductible

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Hospital Confinement Co-Payment

—per day	$200
—maximum Co-Payment per Period of Confinement	$1,000
—maximum Co-Payment per Covered Person per Calendar Year	$2,000
Emergency Room Co-Payment, (waived if admitted within 24 hours)	***$50***
*[• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by a Non-Network Provider	$50]*

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	20%
• if treatment, services or supplies are given by a***n*** *[Non]****Out***-Network Provider	40%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit: $10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE PPO (with Co-payment)**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given by a Network Provider:

• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50

• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible—If treatment services or supplies are given by an *[Non]* ***Out***-Network Provider

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (*[Non]***Out***-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• if treatment, services or supplies are given by a Network Provider	None
• if treatment, services or supplies are given by a***n*** *[Non]***Out***-Network Provider	30%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

SCHEDULE OF INSURANCE AND PREMIUM RATES **EXAMPLE POS**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given or referred by a PCP:

• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year

Calendar Year Cash Deductible—If treatment services or supplies are given by a Non-referred Provider

Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in ***[How This Policy Interacts With]* Medicare *as Secondary Payor***, ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, **except as stated below**
• if treatment, services or supplies are given or referred by a non referred Provider	20%, **except as stated below**

Exception: for Mental and Nervous and Substance Abuse charges

• if treatment, services or supplies are given or referred by the PCP	5%
• if treatment, services or supplies are given by a non-referred Provider	25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000

PREMIUM RATES ***[PLANS B, C, D, E]***

[The ***initial*** monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Coverage	**Premium Rate**
Health Benefits	
—per Employee	$9999.99
—per Employee and spouse	$9999.99
—per Employee and children	$9999.99
—per Employee, spouse and children	$9999.99]

[Carrier] has the right to change any premium rate(s) set forth above at the times and in the manner established by the provision **Premium Rate Changes** section of this Policy.

GENERAL PROVISIONS

THE POLICY

The entire Policy consists of:

[a. the forms shown in the Policy Index as of the Effective Date;

b.] the Policyholder's application, a copy of which is attached to this Policy;

[c.] any riders, [endorsements] or amendments to this Policy and

[d.]the individual applications, if any, of the persons covered.

STATEMENTS

No statement will avoid the insurance under this Policy, or be used in defense of a claim hereunder unless:

a. in the case of the Policyholder, it is contained in the application signed by the Policyholder; or

b. in the case of a Covered Person, it is contained in a written instrument signed by the Covered Person, and a copy of which is furnished to the Covered Person or the Covered Person's beneficiary.

All statements will be deemed representations and not warranties.

INCONTESTABILITY OF THIS POLICY

There will be no contest of the validity of this Policy, except for not paying premiums, after it has been in force for 2 years ***from the Effective Date***.

No statement in any application, except a fraudulent statement, made by the Policyholder or by a person insured under this Policy shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred after such insurance has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

[If this Policy replaces the policy of another insurer, [Carrier] may rescind this Policy based on misrepresentations made in the Policyholder's or a Covered Person's signed application for up to two years from this Policy's Effective Date.]

AMENDMENT

This Policy may be amended, at any time, without the consent of the Covered Persons or of anyone else with a beneficial interest in it. This can be done through written request made by the Policyholder and agreed to by [Carrier]. [Carrier] may also make amendments to this Policy, as provided in b. and c. below. [Carrier] will give the Policyholder 30 days advance written notice. An amendment will not affect benefits for a service or supply furnished before the date of change.

Only an officer of [Carrier] has authority: to waive any conditions or restrictions of this Policy; or to extend the time in which a premium may be paid; or to make or change a Policy; or to bind [Carrier] by a promise or representation or by information given or received.

No change in this Policy is valid unless the change is shown in one of the following ways:

[a. It is shown in an endorsement on it signed by an officer of [Carrier].]

[b.] In the case of a change in this Policy that has been automatically made to satisfy the requirements of any state or federal law that applies to this Policy, as provided in the **Conformity With Law** section, it is shown in an amendment to it that is signed by an officer of [Carrier].

[c.] In the case of a change required by [Carrier], it is shown in an amendment to it that:

- is signed by an officer of [Carrier]; and
- is accepted by the Policyholder as evidenced by payment of a premium becoming due under this Policy on or after the Effective Date of such change.

[d.]In the case of a written request by the Policyholder for a change, it is shown in an amendment to it signed by the Policyholder and by an officer of [Carrier].

AFFILIATED COMPANIES

If the Policyholder asks [Carrier] in writing to include an Affiliated Company under this Policy, and [Carrier] gives written approval for the inclusion, [Carrier] will treat Employees of that company like the Policyholder's Employees. [Carrier's] written approval will include the starting date of the company's coverage under this Policy. But each eligible Employee of that company must still meet all the terms and conditions of this Policy before becoming covered.

An Employee of the Policyholder and one or more Affiliated Companies will be considered an Employee of only one of those Employers for the purpose of this Policy. That Employee's service with multiple Employers will be treated as service with that one.

The Policyholder must notify [Carrier] in writing when a company stops being an Affiliated Company. As of this date, this Policy will be considered to end for Employees of that Employer. This applies to all of those Employees except those who, on the next day, are employed by the Policyholder or another Affiliated Company as eligible Employees.

PREMIUM AMOUNTS

The premium due on each premium due date is the sum of the premium charges for the coverage then provided. Those charges are determined from the premium rates then in effect and the Employees ***and Dependents*** then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Policyholder and [Carrier].

The following will apply if one or more premiums paid include premium charges for an Employee ***and/or Dependent*** whose coverage has ended before the due date of that premium. [Carrier] will not have to refund more than [the amount of a. minus b.:

a. The amounts of the premium charges for such Employee that were included in the premiums paid for the two months period immediately before the date [Carrier] receives written notice from the Policyholder that the Employee's ***and/or Dependent's*** coverage has ended.

b. The amount of any claims paid to an Employee for the Employee's claims or to a member of the Employee's family unit after that person's coverage has ended.]

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Policyholder to [Carrier]. Each may be paid at a [Carrier's] office [or to one of its authorized agents.] One is due on each premium due date stated on the first page of this Policy. The Policyholder may pay each premium other than the first within 31 days of the premium due date without being charged interest. Those days are known as the grace period. The Policyholder is liable to pay premiums to [Carrier] for the *[first]* time this Policy is in force. Premiums unpaid after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be determined by [Carrier] from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The premium rates in effect on the Effective Date as shown in this Policy's Schedule. [Carrier] has the right to change premium rates as of any of these dates:

a. Any premium due date.

b. Any date that an Employer becomes, or ceases to be, an Affiliated Company.

c. Any date that the extent or nature of the risk under this Policy is changed:

- by amendment or this Policy; or
- by reason of any provision of law or any government program or regulation; or
- if this Policy supplements or coordinates with benefits provided by an other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date [Carrier's] obligation under this Policy is changed because of a change in such other benefits.

d. At the discovery of a clerical error or misstatement as described below.

e. As of the date the nature of the Policyholder's business changes.

[Carrier] will give the Policyholder 30 days advance written notice when a change in the premium rates is made.

PARTICIPATION REQUIREMENTS

If this Policy provides coverage on a Non-contributory basis (the Policyholder pays the entire premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Non-contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or

b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

If this Policy provides coverage on a Contributory basis (the Employee pays part of the premium), [75%] of the Employees eligible for insurance must be enrolled for coverage. If Dependent coverage is provided on a Contributory basis, [75%] of the Employees eligible for Dependent coverage must enroll their eligible Dependents. (If an eligible Employee is not covered by this Policy because:

a. the Employee is covered as a Dependent under a spouse's coverage; or

b. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count this person as being covered by this Policy for the purposes of satisfying participation requirements.)

CLERICAL ERROR—MISSTATEMENTS

Neither clerical error by the Policyholder, nor the [Carrier] in keeping any records pertaining to coverage under this Policy, nor delays in making entries thereon, will ***not*** invalidate coverage ***which would*** otherwise ***be in force, or continue coverage which would otherwise be*** validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the Policyholder will be limited to the period of 12 months preceding the date of [Carrier's] receipt of satisfactory evidence that such adjustments should be made.

If the age of an Employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not the person's coverage would have been accepted by [Carrier], or the amount of coverage, subject to this Policy's **Incontestability** section, the true facts will be used in determining whether coverage is in force under the terms of this Policy, and in what amounts.

TERMINATION OF THE POLICY—RENEWAL PRIVILEGE

[Carrier] has the right to cancel this Policy on any premium due date subject to 30 days advance written notice to the Policyholder for the following reasons:

a. During or at End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this Policy will automatically end when that period ends. But the Policyholder may write to [Carrier], in advance, to ask that this Policy be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Policy will end on the date requested. ***The Policyholder is liable to pay premiums to [Carrier] for the time this Policy is in force.***

[b. the Policyholder moves its principal place of business outside the State of New Jersey;]

*[c.]***b.*** subject to the statutory notification requirements, [Carrier] ceases to do business in the small group market;

*[d.]***c.*** with respect to Contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.); or

*[e.]***d.*** with respect to Non-contributory Policies, less than [75%] of the Employer's eligible Employees are covered by this Policy. (If an eligible Employee is not covered by this Policy because:

1. the Employee is covered as a Dependent under a spouse's coverage; or
2. the Employee is covered under a Health Maintenance Organization plan offered by the Policyholder,

[Carrier] will count that Employee as being covered by this Policy for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Policyholder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Policy is issued for a term of one (1) year from the Effective Date shown in the first page of this Policy. All Policy Years and Policy Months will be calculated from the Effective Date. All periods of insurance hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Policyholder's place of business.

The Policyholder may renew this Policy for a further term of one (1) year, on the first and each subsequent Policy Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Policy's **Premium Amounts** section.

However, [Carrier] has the right to non-renew this Policy on any Policy Anniversary if the Policyholder is no longer a Small Employer ***in accordance with the laws in the State of New Jersey***.

The Employer must certify to [Carrier] the Employer's status as a Small Employer every year. Certification must be given to [Carrier] within 10 days of the date [Carrier] requests it. If Employer fails to do this, [Carrier] retains the right to take the actions described above as of the Employer's Policy Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify [Carrier] within 30 days. [Carrier] has the right to change the rates [Carrier] charges for this Policy if this happens. If the Employer fails to notify [Carrier] within 30 days, [Carrier] has the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

[DIVIDENDS

[Carrier] will determine the share, if any, of its divisible surplus allocable to this Policy as of each Policy Anniversary, if this Policy stays in force by the payment of all premiums to that date. The share will be credited to this Policy as a dividend as of that date.

Each dividend will be paid to the Policyholder in cash unless the Policyholder asks that it be applied toward the premium then due or future premiums due.

[Carrier's] sole liability as to any dividend is as set forth above.

If the aggregate dividends under this Policy and any other policy(ies) of the Policyholder exceed the aggregate payments towards their cost made from the Employer's own funds, the Policyholder will see that an amount equal to the excess is applied for the benefit of Covered Persons.]

EMPLOYEE'S CERTIFICATE

[Carrier] will give the Policyholder an individual certificate of coverage to give each covered Employee. It will describe the Employee's coverage under this Policy. It will include:

(1) to whom [Carrier] pays benefits,

(2) any protection and rights when the coverage ends and

(3) claim rights and requirements.

In the event this Policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the Policyholder for delivery to affected Employees.

OFFSET

[Carrier] reserves the right, before paying benefits to a Covered Person, to use the amount of payment due to offset a claims payment previously made in error.

CONTINUING RIGHTS

[Carrier's] failure to apply terms or conditions does not mean that [Carrier] waives or gives up any future rights under this Policy.

ASSIGNMENT BY POLICYHOLDER

Assignment or transfer of the interest of the Policyholder under this Policy will not bind [Carrier] without [Carrier's] written consent thereto.

CONFORMITY WITH LAW

Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Covered Person resides, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on this Policy until 60 days after a Covered Person files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

WORKERS' COMPENSATION

The health benefits provided under this Policy are not in place of, and do not affect requirements for coverage by Workers' Compensation.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under this Policy may be sent by United States mail, postage prepaid, addressed as follows:

If to [Carrier]: To the last address on record with the Policyholder.

If to a Covered Person: To the last address provided by the Covered Person on an enrollment or change of address form actually delivered to [Carrier].

If to the Policyholder: To the last address of the Policyholder on record with [Carrier].

RECORDS—INFORMATION TO BE FURNISHED

[Carrier] will keep a record of the Covered Persons. It will contain key facts about their coverage.

At the times set by [Carrier], the Policyholder will send the data required by [Carrier] to perform its duties under this Policy, and to determine the premium rates and certify status as a Small Employer. All records of the Policyholder and of the Employer which bear on this Policy must be open to [Carrier] for its inspection at any reasonable time.

[Carrier] will not have to perform any duty that depends on such data before it is received in a form that satisfies [Carrier]. The Policyholder may correct wrong data given to [Carrier], if [Carrier] has not been harmed by acting on it. A person's coverage under this Policy will not be made invalid by failure of the Policyholder or the Employer, due to clerical error, to record or report the Employee for coverage.

The Policyholder will furnish [Carrier] the Employee and Dependents eligibility requirements of this Policy that apply on the Effective Date. Subject to [Carrier's] approval, those requirements will apply to the Employee and Dependent coverage under this Policy. The Policyholder will notify [Carrier] of any change in the eligibility requirements of this Policy, but no such change will apply to the Employee or Dependent coverage under this Policy unless approved in advance by [Carrier].

The Policyholder will notify [Carrier] of any event, including a change in eligibility, that causes termination of a Covered Person's coverage immediately, or in no event later than the last day of the month in which the event occurs. The liability of [Carrier] to arrange or provide benefits for a person ceases when the person's coverage ends under this Policy. [If the Policyholder fails to notify [Carrier] as provided above, [Carrier] will be entitled to reimbursement from the Policyholder of any benefits paid to any person after the person's coverage *[has]* ***should have*** ended.]

CLAIMS PROVISIONS

A claimant's right to make a claim for any benefits provided by this Policy is governed as follows:

[NOTICE OF LOSS

A claimant should send a written notice of claim to [Carrier] within 20 days of a loss. No special form is required to do this. The notice need only identify the claimant and the Policyholder.

When [Carrier] receives the notice, it will send a proof of claim form to the claimant.

The claimant should receive the proof of claim form within 15 days of the date [Carrier] received the notice of claim.

If the form is received within such time, it should be completed, as instructed, by all persons required to do so. Additional proof, if required, should be attached to the form.

If the form is not received within such time, the claimant may provide written proof of claim to [Carrier] on any reasonable form. Such proof must state the date the Injury or Illness began and the nature and extent of the loss.]

PROOF OF LOSS

Proof of loss must be sent to [Carrier] within 90 days of the loss.

If a notice or proof is sent later than 90 days of the loss, [Carrier] will not deny or reduce a claim if the notice or proof was sent as soon as possible.

PAYMENT OF CLAIMS

[Carrier] will pay all benefits to which the claimant is entitled as soon as [Carrier] receives written proof of loss. All benefits will be paid as they accrue. Any benefits unpaid at the Covered Person's death will be paid as soon as [Carrier] receives due proof of the death to one of the following:

a. his or her estate;
b. his or her spouse;
c. his or her parents;
d. his or her children;
e. his or her brothers and sisters; or
f. any unpaid provider of health care services.

[When an Employee files proof of loss, he or she may direct [Carrier], in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. [Carrier] may honor such direction at [Carrier's] option. The Employee may not assign his or her right to take legal action under this Policy to such provider.]

PHYSICAL EXAMS

[Carrier], at its expense, has the right to examine the insured. This may be done as often as reasonably needed to process a claim. [Carrier] also has the right to have an autopsy performed, at its expense.

LIMITATIONS OF ACTIONS

[An Employee] ****A Covered Person**** cannot bring a legal action against this Policy until 60 days from the date he or she files proof of loss. And he or she cannot bring legal action against this Policy after three years from the date he or she files proof of loss.

[PLANHOLDERS

The Policyholder is the Trustee named by a trust agreement. This agreement permits certain Employers to insure their Employees for the benefits provided by this Policy. Employers who do so are Planholders.

The Policyholder acts for the Planholders in all matters of this Policy. Such actions bind all Planholders.

How an Employer becomes a Planholder

An Employer must submit a signed application in which he:

- agrees to participate in the trust, and
- applies for the insurance provided by this Policy for his Employees.

When an Employer becomes a Planholder

The Policyholder and [Carrier] will agree on the date an Employer becomes a Planholder. This date will be stated in writing by [Carrier].

When an Employer ceases to be a Planholder

The Policyholder can end an Employer's status as a Planholder. To do so, he or she must give [Carrier] 30 days advance written notice.

[Carrier] can end insurance for a Planholder. To do so, it must give the Policyholder 30 days advance written notice.

Data needed

The Policyholder must provide [Carrier] with all the data needed to compute premiums and carry out the terms of this Policy. [Carrier] can examine the records of the Policyholder and each Planholder at any reasonable time.]

[**Note:** This text, which may be modified by each carrier in order to accommodate various trust agreements, is only to be used if coverage is to be issued through a Multiple Employer Trust (MET)]

DEFINITIONS

The words shown below have special meanings when used in this Policy. Please read these definitions carefully. [Throughout this Policy, these defined terms appear with their initial letter capitalized.]

Actively at Work or **Active Work** means performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.

Alcohol Abuse means abuse of or addiction to alcohol.

Ambulance means a certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by state and local law.

Ambulatory Surgical Center means a Facility mainly engaged in performing Outpatient Surgery. It must:

a. be staffed by Practitioners and Nurses, under the supervision of a Practitioner;
b. have permanent operating and recovery rooms;
c. be staffed and equipped to give emergency care; and

d. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commission or the Accreditation Association for Ambulatory Care; or
b. approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as an Ambulatory Surgical Center if it is part of a Hospital.

Anniversary Date means the date which is one year from the Effective Date of this Policy and each succeeding yearly date thereafter.

Affiliated Company means a corporation or other business entity affiliated with the Policyholder through common ownership of stock or assets.

Birthing Center means a Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a. provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b. be staffed and equipped to give emergency care; and
c. have written back-up arrangements with a local Hospital for emergency care.

[Carrier] will recognize it if:

a. it carries out its stated purpose under all relevant state and local laws; or
b. it is approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c. it is approved for its stated purpose by Medicare.

[Carrier] does not recognize a Facility as a Birthing Center if it is part of a Hospital.

Board means the Board of Directors of the New Jersey Small Employer Health Program.

Calendar Year means each successive 12 month period which starts on January 1 and ends on December 31.

Cash Deductible means the amount of Covered Charges that a Covered Person must pay before this Policy pays any benefits for such charges. ***Cash Deductible does not include Co-Insurance, Co-Payments and Non-Covered Charges.*** See the **The Cash Deductible** section of this Policy for details.

Co-Insurance means the percentage of a Covered Charge that must be paid by a Covered Person. Co-Insurance does **not** include Cash Deductibles, Co-Payments or Non-Covered Charges.

Co-Payment means a specified dollar amount a Covered Person must pay for specified Covered Charges.

Covered Charges are Reasonable and Customary charges for the types of services and supplies described in the **Coverage Charges** and **Covered Charges With Special Limitations** section of this Policy. The services and supplies must be:

a. furnished or ordered by a recognized health care Provider; and
b. Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of this Policy, [Carrier] pays benefits for Covered Charges incurred by a Covered Person while or he or she is insured by this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Covered Person means an Eligible Employee or a Dependent who is insured under this Policy.

Current Procedural Terminology (C.P.T.) means the most recent edition of an annually revised listing published by the American Medical Association which assigns numerical codes to procedures and categories of medical care.

Custodial Care means any service or supply, including room and board, which:

a. is furnished mainly to help a person meet his or her routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

Even if a Covered Person is in a Hospital or other recognized Facility, [Carrier] does not pay for care if it is mainly custodial.

Dependent means an Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. *[his or her]* unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. Full-time students status will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Dependent Coverage** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children.
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

***Dependent's Eligibility Date means the later of:**

a. the Employee's Eligibility Date; or

b. the date the person first becomes a Dependent.*

Diagnostic Services means procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples are:

a. radiology, ultrasound and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's and other electronic diagnostic tests.

Except as allowed under the Preventive Care Covered Charge, Diagnostic Services do not include procedures ordered as part of a routine or periodic physical examination or screening examination.

Discretion means the [Carrier's] sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

Durable Medical Equipment is equipment which ***is***:

a. *[is]* designed and able to withstand repeated use;
b. *[is]* primarily and customarily used to serve a medical purpose;
c. *[is]* generally not useful to a Covered Person in the absence of an Illness or Injury; and
d. *[is]* suitable for use in the home.

Some examples are walkers, wheelchairs, hospital-type beds, breathing equipment and apnea monitors.

Among other things, Durable Medical Equipment does not include adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to the home or place of business, waterbeds, whirlpool baths and exercise and massage equipment.

Effective Date means the date on which coverage begins under this Policy for the Employer, or the date coverage begins under this Policy for an Employee or Dependent, as the context in which the term is used suggests.

Employee means a Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Policy's conditions of eligibility. ***Employees who work on a temporary or substitute basis are not considered to be Employees for the purpose of this Policy.***

***Employee's Eligibility Date means the later of:**

a. the date of employment; or

b. the day after any applicable waiting period ends.*

Employer means [ABC Company].

Experimental or Investigational means [Carrier] determines a service or supply is:

a. not of proven benefit for the particular diagnosis or treatment of a particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), [Carrier] will not cover any services or supplies, including

treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

[Carrier] will also not cover any technology or any hospitalization primarily to receive such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a particular condition.

*[Governmental approval of technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a particular condition.

[Carrier] will apply the following five criteria in determining whether services or supplies are Experimental or Investigational:

a. Any medical device, drug, or biological product must have received final approval to market by the FDA for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition may require that any or all of the five criteria be met;]*

b. Conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by non affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;

c. Demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;

d. Proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes; as defined item c. above, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Extended Care Center means a Facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or

b. approved for its stated purpose by Medicare. In some places, an "Extended Care Center" may be called a "Skilled Nursing Center."

Facility means a place [Carrier] is required by law to recognize which:

a. is properly licensed, certified, or accredited to provide health care under the laws of the state in which it operates; and

b. provides health care services which are within the scope of its license, certificate or accreditation and are covered by this Policy.

Full-Time means a normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

Generic Drug means an equivalent Prescription Drug containing the same active ingredients as a brand name Prescription Drug but costing less. The equivalent must be identical in strength and form as required by the FDA.

Government Hospital means a Hospital operated by a government or any of its subdivisions or agencies, including but not limited to a Federal, military, state, county or city Hospital.

Home Health Agency means a Provider which *[mainly]* provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. [Carrier] will recognize it if it is licensed by the state in which it operates, or it is certified to participate in Medicare as a Home Health Agency.

Hospice means a *[Facility]* ***Provider*** which *[mainly]* provides palliative and supportive care for terminally ill ***or terminally injured*** people under a hospice care program. [Carrier] will recognize a hospice if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. approved for its stated purpose by Medicare; or

b. it is accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

Hospital means a Facility which mainly provides Inpatient care for Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited as a Hospital by the Joint Commission or

b. approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent home, rest or nursing Facility, or a Facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A Facility for the aged or substance abusers is also not a Hospital.

Illness means a sickness or disease suffered by a Covered Person. A Mental and Nervous Condition is not an Illness.

Initial Dependent means those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

Injury means all damage to a Covered Person's body due to accident, and all complications arising from that damage.

Inpatient means a Covered Person who is physically confined as a registered bed patient in a Hospital or other recognized health care Facility.

Joint Commission means the Joint Commission on the Accreditation of Health Care Facilities.

Late Enrollee means an eligible Employee or Dependent who requests enrollment under this Policy more than *[*30*]* days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Policy.

Medical Emergency means the sudden, unexpected onset, due to Illness or Injury of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. Heart attacks, strokes, convulsions, severe burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness are Medical Emergencies.

Medically Necessary and Appropriate means that a service or supply is provided by a recognized health care Provider, and [Carrier] determines at its Discretion, that it is:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;

b. provided for the diagnosis, or the direct care and treatment, of the condition, Illness or Injury;

c. in accordance with ***generally*** accepted medical *[standards in the community at the time]* ***practice***;

d. not for the convenience of a Covered Person;

e. the most appropriate level of medical care the Covered Person needs; ***and***

[f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and]

*[g.]***f.*** furnished within the framework of generally accepted methods of medical management currently used in the United States.

The fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

Medicaid means the health care program for the needy provided by Title XIX of the ***United States*** Social Security Act, as amended from time to time.

Medicare means Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the ***United States*** Social Security Act, as amended from time to time.

Mental Health Center *means a Facility which* mainly provide treatment for people with mental health problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; *[or]*

b. approved for its stated purpose by Medicare; ***or***

c. accredited or licensed by the state of New Jersey to provide mental health services.

Mental and Nervous Condition means a condition which manifests symptoms which are primarily mental or nervous, for which the primary treatment is psychotherapy or psychotherapeutic methods or

psychotropic medication, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In determining whether or not a particular condition is a Mental and Nervous Condition, [Carrier] may refer to the current edition of the Diagnostic and Statistical manual of Mental Disorders of the American Psychiatric Association.

Newly Acquired Dependent means an eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

Non-Covered Charges are charges which do not meet this Policy's definition of Covered Charges, or which exceed any of the benefit limits shown in this Policy, or which are specifically identified as Non-Covered Charges or are otherwise not covered by this Policy.

Nurse means a registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

*[**Outpatient** means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

Period of Confinement means consecutive days of Inpatient services provided to an Inpatient or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized Facility occurs within 90 days or less. [Carrier] determines if the cause(s) of the confinements are the same or related.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan".]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder".]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.

Outpatient means a Covered Person who is registered at a recognized health care Facility who is not an Inpatient.

Per Lifetime means during the lifetime of an individual, regardless of whether he or she is covered under this Policy or any other policy or plan:

a. as an Employee or Dependent; and
b. with or without interruption.

Plan means the [Carrier's] group health benefit plan purchased by the Employer. [Note: If the "Plan" definition is employed, references in this Policy to "Policy" should be changed to read "Plan".]

Planholder means the Employer who purchased group health benefit plan. [Note: If the "Planholder" definition is employed, references in this Policy to "Policyholder" should be changed to read "Planholder".]

Policy means this group policy, including the application and any riders, amendments, or endorsements, between the Employer and [Carrier].

Policyholder means the Employer who purchased this Policy.

Practitioner means a person [Carrier] is required by law to recognize who:

a. is properly licensed or certified to provide medical care under the laws of the state where he or she practices; and
b. provides medical services which are within the scope of his or her license or certificate and are covered by this Policy.

Pre-Approval or Pre-Approved means the [Carrier's] written approval for specified services and supplies prior to the date charges are incurred. Charges which are not Pre-Approved are Non-Covered Charges.

Pre-Existing Condition means an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescription Drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before his or her coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by [Carrier], such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccine, well baby care, pap smears, mammography and screening tests.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Reasonable and Customary means an amount that is not more than the usual or customary charge for the service or supply as determined by [Carrier], based on a standard approved by the Board. When [Carrier] decides what is reasonable, it looks at the Covered Person's condition and how severe it is. [Carrier] also looks at special circumstances. The Board will decide a standard for what is Reasonable and Customary under this Policy. The chosen standard is an amount which is most often charged for a given service by a Provider within the range of usual fees charged by most Providers of similar training and experience for the same service within the same geographic area.]*

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. [Carrier] will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by either the Joint Commissioner or the Commission on Accreditation for Rehabilitation Facilities; or
b. approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

Routine Nursing Care means the ***appropriate*** nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in this Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

Skilled Nursing Center (see Extended Care Center.)

Small Employer means any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:

a. intensive care units;
b. cardiac care units;
c. neonatal care units; and
d. burn units.

Substance Abuse means abuse of or addiction to drugs.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. [Carrier] will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; or
b. approved for its stated purpose by Medicare.

Surgery means:

a. the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other ***invasive*** procedures;
b. the correction of fractures and dislocations;
c. Reasonable and Customary pre-operative and post-operative care; or
d. any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting fro the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool or hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

[We, Us, Our and **[Carrier]** mean [Carrier].]

[You, Your and Yours mean the Employer.]

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of *[the]* ***this*** Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Policy, [Carrier] will treat partners, proprietors and independent contractors like Employees if they meet *[the]* ***this*** Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not insure an Employee unless the Employee is an Actively at Work Full-Time Employee.

Enrollment Requirement

[If an employee must pay part of the cost of Employee Coverage,] [Carrier] will not insure the Employee until the Employee enrolls and agrees to make the required payments***, if any***. ***If the Employee does this within [30] days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.***

If the Employee *[does this]* ***enrolls and agrees to make the required payments, if any***:

a. more than ***[*30*]*** days after the *[Employee first becomes eligible]* ***Employee's Eligibility Date***; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

[Carrier] will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation.

However, if an Employee initially waived coverage under this Policy, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, [Carrier] will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Policy has the following waiting periods:

*[Employees in an eligible class on the Effective Date, who have completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least [6] months of continuous Full-Time service with the Employer by that date, are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete 3 months of continuous Full-Time service with the Employer.]]*

Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company [Carrier] will treat the Employee as if only one firm Employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earning to set the rates, determine class, figure benefit amounts, or for any other reason, such Employee's earnings will be figured as the sum of his or her earnings from all covered Employers.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility, which apply

to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

*[The scheduled Effective Date of an Employee's coverage is as follows:

a. if an Employee must pay part of the cost of Employee coverage, then he or she]* ***The Employee*** must elect to enroll and agree to make the required payments, ***if any,*** within *[*30*]* days of *[his or her]* ***the Employee's*** Eligibility Date. If he or she does this within *[*30*]* days of *[his or her]* ***the Employee's*** Eligibility Date, his or her coverage is scheduled to start on *[his or her]* ***the Employee's*** Eligibility Date. ***Such Employee's Eligibility Date is the scheduled Effective Date of an Employee's coverage.***

[b. On non-contributory plans, subject of all the terms of this plan, an Employee's coverage starts on his or her eligibility date.]

When Employee Coverage Ends

An Employee's insurance under this Policy will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Policy.
c. the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d. the last day of the period for which required payments are made for the Employee.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Policy's benefits provisions explain these situations. Read this Policy's provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are ***the Employees***:

a. *[the Employee's]* legal spouse;
b. *[the Employee's]* unmarried Dependent children who are under age 19; and
c. *[the Employee's]* unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be as defined by the accredited school.

A Dependent is not a person who is:

a. on active duty in any armed forces of any country; or
b. eligible for coverage under this Policy as an Employee.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "unmarried Dependent child" includes:

a. his or her legally adopted children,
b. his or her step-children if such step children depend on the Employee for most of their support and maintenance, and
c. children under a court appointed guardianship.

[Carrier] treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. [Carrier] treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical incapacity, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and *[the plan]* ***this Policy***, such a child may stay eligible for Dependent health benefits past this Policy's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Policy's age limit;
b. the child became insured by this Policy ***or any other policy*** before the child reached the age limit, and stayed continuously insured *[until]* ***after*** reaching such limit; and
c. the child depends on the Employee for most of *[their]* ***his or her*** support and maintenance.

But, for the child to stay eligible, the Employee must send [Carrier] written proof that the child is incapacitated and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. [Carrier] can ask for periodic proof that the child's condition continues. But, after two years, [Carrier] cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent and agrees to make the required payments *[after the end of the enrollment period]* ***more than [30] days after the Dependent's Eligibility Date***;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy ***and stated at that time that such waiver was*** because they were covered under another group plan, and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. ***Coverage will take effect as of the date one of the above events occurs.***

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date *[he or she becomes eligible]* ***required pursuant to a court order***.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this *[on or before the Employee's]* ***within [30] days of the Dependent's*** Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the *[Employee's]* ***Dependent's*** Eligibility Date, or
b. the date the Employee becomes insured for Employee coverage.

If the Employee does this *[within or after the enrollment period, the]* ***more than [30] days after the Dependent's Eligibility Date, [Carrier] will consider the Dependent a Late Enrollee***. Coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify [Carrier] of a Newly Acquired Dependent within *[the enrollment period]* ***[30] days after the Dependent's Eligibility Date***. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child will be covered from the later of:
a. the date the Employee notifies [Carrier] and agrees to make any additional payments, or
b. the *[date]* ***Dependent's Eligibility Date for*** the newly Acquired Dependent *[is first eligible]*.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care Facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such Facility or until home confinement ends.

Newborn Children

[Carrier] will cover an Employee's newborn child for 31 days from the date of birth. Health benefits may be continued beyond such 31 day period as stated below:
a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid.
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the request is not made and the premium is not paid within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's insurance under this Policy will end on the first of the following dates:
a. [the date] Employee coverage ends;
b. the date the Employee stops being a member of a class of Employees eligible for such coverage;
c. the date this Policy ends;
d. the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.
e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.
f. ***at 12:01 a.m. on*** the date the Dependent stops being an eligible Dependent. *[This happens at 12:01 a.m. on the date:
   - the child attains the Policy's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.]*

Read this Policy carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have conversion rights.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

The Employer XYZ Health Care Network, and the [Carrier]

This Policy encourages a Covered Person to use services provided by members of [XYZ Health Care Network a Preferred Provider Organization (PPO).] A PPO is a network of health care providers located in the Covered Person's geographical area. In addition to an identification card, the Covered Person will periodically be given up-to-date lists of [XYZ Health Care Network] preferred providers.

Use of the network is strictly voluntary, but [Carrier] generally pays a higher level of benefits for most covered services and supplies furnished to a Covered Person by [XYZ Health Care Network]. Conversely, [Carrier] generally pays a lower level of benefits when covered services and supplies are not furnished by [XYZ Health Care Network] (even if an [XYZ Health Care Network] Practitioner orders the services and supplies). Of course, a Covered Person is always free to be treated by any Practitioner or Facility. And, he or she is free to change Practitioners or Facilities at any time.

A Covered Person may use any [XYZ Health Care Network] Provider. He or she just presents his or her [XYZ Health Care Network] identification card to the [XYZ Health Care Network] Practitioner or Facility furnishing covered services or supplies. Most [XYZ Health Care Network] Practitioners and Facilities will prepare any necessary claim forms for him or her, and submit the forms to [Carrier]. The Covered Person will receive an explanation of any insurance payments made by this Policy. And if there is any balance due, the [XYZ Health Care Network] Practitioner or Facility will bill him or her directly.

This Policy also has utilization review features. See the **Utilization Review Features** section for details.

What [Carrier] pays is subject to all the terms of this Policy. The Employee should read his or her certificate carefully and keep it available when consulting a Practitioner.

See the Schedule for specific benefit levels, payment rates and payment limits.

If an Employee has any questions after reading his or her Certificate, he or she should call [Carrier] [Group Claim Office at the number shown on his or her identification card.]

[**Note:** Used only if coverage is offered as a PPO.]

POINT OF SERVICE PROVISIONS

Definitions

a. ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the [XYZ] Provider Organization. [Carrier] will supply a list of *[Practitioners]* ***PCPs*** who are members of the [XYZ] Provider Organization to the Covered Person.
b. ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c. ***Network Benefits*** mean the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d. ***Out-Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e. ***Service Area*** means the geographical area which is served by the Practitioners in the [XYZ] Provider Organization.

Provider Organization (PO)

The Provider Organization for this Policy is the [XYZ] Provider Organization. This Policy requires that the Covered Person uses the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits.

The Primary Care *[Physician]* *Practitioner* (PCP)

The PCP will supervise and coordinate the Covered Person's health care in the [XYZ] PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person **must** obtain an authorized referral from his or her PCP **before** he or she visits another Practitioner or Facility. Except in case of a Medical Emergency, if the Covered Person does not comply with these requirements, he or she *[will not]* ***may only*** be eligible for ***Out-***Network Benefits.

[Carrier] *[pays]* ***provides*** Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. [Carrier] pays Out-Network Benefits when covered services and supplies are not authorized by the PCP. If services or supplies are obtained from [XYZ] Providers, but they are not authorized by the PCP ***the Covered Person may only be eligible for*** Out-Network Benefits *[will be provided]*.

A Covered Person may change his or her PCP to another PCP [once per month]. He or she may select another PCP from the list of Practitioners, and notify [XYZ] PO by [phone or in writing].

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Co-Payment. When a Covered Person's PCP refers him or her to another [XYZ] PO Provider, the

Covered Person must pay the Co-Payment to such Provider. [Most [XYZ] PO Practitioners will prepare any necessary claim forms and submit them to [Carrier].]

[Once per calendar year, a female Covered Person may use the services of a [XYZ] PO gynecologist for a routine exam, without referral from her PCP. She must obtain authorization from her PCP for any services beyond a routine exam and tests.]

Out-Network Services

If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. For services which have not been referred by the Covered Person's PCP, whether provided by an [XYZ] PO Provider or otherwise, ***the Covered Person may only be eligible for*** Out-Network Benefits *[will be paid]*.

Emergency Services

If a Covered Person requires services for a Medical Emergency which occurs inside the PO Service Area, he or she must notify and obtain authorization from his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Co-Payment, and such visits must be retrospectively reviewed [by the PCP]. [Carrier] will waive the emergency room Co-Payment if the Covered Person is hospitalized within 24 hours of the visit.

If a Covered Person requires services for a Medical Emergency outside the PO Service Area, the PCP must be notified within 48 hours or as soon as reasonably possible thereafter. Follow-up care is limited to the medical care necessary before the Covered Person can return to the ***PO*** Service Area *[of the EPO]*.

Utilization Review

This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

Benefits

The Schedule shows Network Benefits, Out-Network Benefits, and Co-Payments applicable to the Point of Service arrangement.

What [Carrier] pays is subject to all the terms of this Policy.

[**Note:** Used only if coverage is offered as POS.]

***[SCHEDULE OF INSURANCE AND PREMIUM RATES EXAMPLE POS**

This Policy's classification, and the insurance coverages and amounts which apply to each class are shown below:

CLASS

[All eligible employees]

EMPLOYEE AND DEPENDENT HEALTH BENEFITS

Co-Payment—If treatment, services or supplies are given or referred by a PCP:	
• Physician Visits	$10
• Emergency Room (waived if admitted within 24 hours)	$50
• Hospital Confinement	$100 per day, up to $500 per confinement, $1,000 per Calendar Year
Calendar Year Cash Deductible—If treatment services or supplies are given by a Non-referred Provider	
Per Covered Person	[$250, $500 or $1,000]
Per Covered Family	[$500, $1,000 or $2,000] Note: Must be individually satisfied by 2 separate Covered Persons

Medicare Alternate Deductible

For a Covered Person who is eligible for Medicare by reason of a disability, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible **plus** what Parts A and B of Medicare would have paid had the Covered Person been so insured.

After the 18 month period described in **How This Policy Interacts With Medicare,** ends with respect to a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease, but is not insured by both Parts A and B, the Medicare Alternate Deductible is equal to the Cash Deductible plus what Parts A and B of Medicare would have paid had the Covered Person been so insured.

Emergency Room Co-Payment, (waived if admitted within 24 hours) (Out-Network Provider)	$50

Co-Insurance

Co-Insurance is the percentage of a Covered Charge that must be paid by a Covered Person. However, [Carrier] will waive the Co-Insurance requirement once the Co-Insurance Cap has been reached. This Policy's Co-Insurance, as shown below, does not include penalties incurred under this Policy's Utilization Review provisions, or any other Non-Covered Charge.

The **Co-Insurance** for this Policy is as follows:

• if treatment, services or supplies are given by the PCP	None, **except as stated below**
• if treatment, services or supplies are given or referred by a non-referred Provider	20%, **except as stated below**
Exception: for Mental and Nervous and Substance Abuse charges	
• if treatment, services or supplies are given or referred by the PCP	5%
• if treatment, services or supplies are given by a non-referred Provider	25%

The **Coinsured Charge Limit** means the amount of Covered Charges a Covered Person must incur before no Co-Insurance is required, **except as stated below.**

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the **Coinsured Charge Limit.**

Coinsured Charge Limit:	$10,000]*

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: [Carrier] payments will be reduced or limited if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible

Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before [Carrier] pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges. Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, [Carrier] pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what [Carrier] pays is based on all the terms of this Policy.

Family Deductible Limit

This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, [Carrier] pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Co-Insurance or Co-Payments, for the rest of that Calendar Year. What [Carrier] pays is based on all the terms of this Policy.

Co-Insurance Cap

This Policy limits Co-Insurance amounts each Calendar Year **except** as stated below. The Co-Insurance Cap cannot be met with:

a. Non-Covered Charges;

b. Cash Deductibles;
c. Co-Insurance *[paid by a Covered Person]* for the treatment of Mental and Nervous Conditions and Substance Abuse; and
d. Co-Payments.

There are Co-Insurance Caps for:
a. each Covered Person; and
b. each Covered Family.

The Co-Insurance Caps are shown in the Schedule.

Each Covered Person's Co-Insurance amounts are used to meet his or her own Co-Insurance Cap, and are combined with Co-Insurance amounts from other covered family members to meet the covered family's Co-Insurance Cap. But all amounts used to meet the cap must actually be paid by a Covered Person out of his or her own pocket.

Once the Covered Person's Co-Insurance amounts in a Calendar Year exceed the individual cap, [Carrier] will waive his or her Co-Insurance for the rest of that Calendar Year.

Once two Covered Persons in a family meet their individual Co-Insurance amounts, [Carrier] will waive the family's Co-Insurance for the rest of that Calendar Year.

Exception: Charges for Mental and Nervous Conditions and Substance Abuse treatment are not subject to or eligible for the Co-Insurance Cap.

Payment Limits

[Carrier] limits what [Carrier] will pay for certain types of charges. [Carrier] also limits what [Carrier] will pay for all Illness or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans

The benefits [Carrier] will pay may be affected by a Covered Person being covered by two or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits [Carrier] will pay may also be affected by Medicare. Read the ***[How This Policy Interacts With]* Medicare *as Secondary Payor*** section for an explanation of how this works.

If This Plan Replaces Another Plan

The Employer who purchased this Policy may have purchased it to replace a plan the Employer had with some other insurer.

The Covered Person may have incurred charges for covered expenses under the Employer's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:
a. the charges were incurred during the Calendar Year in which this Policy starts;
b. this Policy would have paid benefits for the charges, if this Policy had been in effect;
c. The Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d. this Policy starts right after the old plan ends.

Extended Health Benefits

If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, [Carrier] will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

[Carrier] will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what [Carrier] will pay is based on all the terms of this Policy.

[Carrier] does not pay for charges due to other conditions. And [Carrier] does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:
a. the date the Total Disability ends; or
b. one year from the date the person's insurance under this Policy ends; or
c. the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to [Carrier] that he or she or his or her Dependent is Totally Disabled, if [Carrier] requests it.

*[COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

Hospital Co-Payment Requirement

Each time a Covered Person is confined in a Hospital, he or she must pay a $200 Co-Payment for each day of confinement, up to a maximum of $1,000 per confinement, subject to a maximum $2,000 Co-Payment per Calendar Year.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

COVERED CHARGES

This section lists the types of charges [Carrier] will consider as Covered Charges. But what [Carrier] will pay is subject to all the terms of this Policy. Read the entire Policy to find out what [Carrier] limits or excludes.

Hospital Charges

[Carrier] covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But [Carrier] limits what [Carrier] pays each day to the room and board limit shown in the Schedule. And [Carrier] covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, [Carrier] covers the charges the same way [Carrier] covers charges for any Illness.

[Carrier] will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And [Carrier] covers emergency room treatment, subject to this Policy's **Emergency Room Co-Payment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what [Carrier] pays for Hospital charges.

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered with Special Limitations** section of this Policy.

Emergency Room Co-Payment Requirement

Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a [$50.00] Co-Payment, if he or she is not admitted within 24 hours.

Pre-Admission Testing Charges

[Carrier] covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. [Carrier] only covers these tests if the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, [Carrier] will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.]*

Extended Care *[and]* *or* Rehabilitation Charges

Subject to [Carrier's] Pre-Approval [Carrier] covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And [Carrier] covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a. *[start within 2 days of a Hospital stay; and]* ***(Reserved)***
b. be due to the same or a related condition that necessitated the Hospital stay.

[And [Carrier] will only cover] ***Coverage for Extended Care and Rehabilitation, combined, is limited to*** the first 120 days of confinement in each Calendar year. Charges for any additional days are a Non-Covered Charge.

But [Carrier] limits what [Carrier] will pay for the treatment of Mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Extended Care *[and]* *or* Rehabilitation charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Home Health Care Charges

Subject to [Carrier's] Pre-Approval, when home health care can take the place of inpatient care, [Carrier] covers such care furnished to a Covered Person under a written home health care plan. [Carrier] covers all Medically Necessary and Appropriate services or supplies, such as:

a. Routine Nursing Care (furnished by or under the supervision of a registered Nurse);
b. physical therapy;
c. occupational therapy;
d. medical social work;
e. nutrition services;
f. speech therapy;
g. home health aide services;
h. medical appliances and equipment, drugs and medications, laboratory services and special meals; and
i. any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services. But, payment is subject to all of the terms of this Policy and to the following conditions:
    a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility.
    b. The services and supplies must be:
        - ordered by the Covered Person's Practitioner;
        - included in the home health care plan; and
        - furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term basis.

    c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once very 60 days.
    d. Each visit by a home health aide, Nurse, or other recognized Provider whose services are authorized under the home health care plan can last up to four hours.
    e. [Carrier] does not pay for:
        - services furnished to family members, other than the patient; or
        - services and supplies not included in the home health care plan.

Home Health Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Practitioner's Charges for Non-Surgical Care and Treatment

[Carrier] covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury. But [Carrier] limits what [Carrier] will pay for the treatment of mental and Nervous Conditions and Substance Abuse. See the **Charges Covered With Special Limitations** section of this Policy.

Practitioner's Charges for Surgery

[Carrier] covers Practitioner's charges for Medically Necessary and Appropriate Surgery. [Carrier] does not pay for cosmetic Surgery.

Second Opinion Charges

[Carrier] covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, [Carrier] covers charges for a third opinion. [Carrier] covers such charges if the Practitioners who give the opinions:

a. are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b. are not business associates of the Practitioner who recommended the Surgery; and
c. in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges

[Carrier] covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges

[Carrier] covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges

Subject to [Carrier] Pre-Approval, [Carrier] covers charges made by a Hospice for palliative and supportive care furnished to a terminally ill ***or terminally injured*** Covered person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal illness ***or terminal injury***.

"Terminally ill" ***or "terminally injured"*** means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally ill ***or terminally injured*** Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, [Carrier] covers any services and supplies including Prescription drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:

a. needed for palliative and supportive care;
b. ordered by the Covered Person's Practitioner;
c. included in the Hospice care program; and
d. furnished by, or coordinated by a Hospice.

[Carrier] does not pay for:

a. services and supplies provided by volunteers or others who do not regularly charge for their services;
b. funeral services and arrangements;
c. legal or financial counseling or services; or
d. treatment not included in the Hospice care plan.

Hospice Care charges which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Alcohol Abuse

[Carrier] pays benefits for the Covered Charges a Covered Person incurs for the treatment of Alcohol Abuse the same way [Carrier] would for any other Illness, if such treatment is prescribed by a Practitioner. But [Carrier] does not pay for Custodial Care, education, or training.

Treatment may be furnished by:

a. a Hospital;

b. a detoxification Facility licensed under New Jersey Public Law 1975, Chapter 305; or
c. a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission.

Pregnancy

This Policy pays for pregnancies the same way [Carrier] would cover an Illness. The charges [Carrier] covers for a newborn child are explained [on the next page.]

Birthing Center Charges

[Carrier] covers Birthing Center charges made by a practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. [Carrier] covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

[Carrier] covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child

[Carrier] covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:
a. nursery charges;
b. charges for routine Practitioner's examinations and tests; and
c. charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, [Carrier] covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies

[Carrier] covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. [Carrier] covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches. But [Carrier] does not pay for replacements or repairs.

Blood

[Carrier] covers blood, blood products, blood transfusions and the cost of testing and processing blood. But [Carrier] does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Ambulance Charges

[Carrier] covers Medically Necessary and Appropriate charges for transporting a Covered Person to:
a. a local Hospital if needed care and treatment can be provided by a local Hospital;
b. the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c. transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But [Carrier] does not pay for chartered air flights. And [Carrier] will not pay for other travel or communication expenses of patients. Practitioners, Nurses or family members.

Durable Medical Equipment

Subject to [Carrier's] Pre-Approval, [Carrier] covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At [Carrier's] option, and with [Carrier's] Pre-Approval, [Carrier] may cover the purchase of such items when it is less costly and more practical than rental. But [Carrier] does not pay for:
a. any purchases without [Carrier's] advance written approval;
b. replacements or repairs; or
c. the rental or purchase of items (such as air conditioners, exercise equipment, saunas and air humidifiers) which do not fully meet the definition of Durable Medical Equipment.

Charges for Durable Medical Equipment which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Treatment of Wilm's Tumor

[Carrier] pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. [Carrier] treats such charges the same way [Carrier] treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. [Carrier] pays benefits for this treatment even if it is deemed Experimental or Investigational. What [Carrier] pays is based on all of the terms of this Policy.

X-Rays and Laboratory Tests

[Carrier] covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's **Preventive Care** section, [Carrier] does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs

[[Carrier] covers drugs which require a Practitioner's prescription. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration, in no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.]

COVERED CHARGES WITH SPECIAL LIMITATIONS

Dental Care and Treatment

[Carrier] covers:
a. the diagnosis and treatment of oral tumors and cysts; and
b. the surgical removal of bony impacted teeth.

[Carrier] also covers treatment of an Injury to natural teeth or the jaw, but only if:
a. the Injury occurs while the Covered Person is insured under any health benefit plan;
b. the Injury was not caused, directly or indirectly by biting or chewing; and
c. all treatment is finished within 6 months of the date of the Injury.

Treatment includes replacing natural teeth lost due to such Injury. But in no event does [Carrier] cover orthodontic treatment.

Treatment for Temporomandibular Joint Disorder (TMJ)

[Carrier] covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, [Carrier] does not cover any charges for orthodontia, crowns or bridgework.

Prosthetic Devices

[Carrier] limits what [Carrier] pays for prosthetic devices. Subject to [Carrier] Pre-Approval, [Carrier] covers only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Covered Person's body, or be needed due to a functional birth defect in a covered Dependent child. [Carrier] does not pay for replacements, unless they are Medically Necessary and Appropriate. [Carrier] does not pay for repairs, wigs, or dental prosthetics or devices.

Charges for Prosthetic Devices which are not Pre-Approved by [Carrier] are Non-Covered Charges.

Mammogram Charges

[Carrier] covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:
[Carrier] will cover charges for:
a. one baseline mammogram for a female Covered Person, ages 35-39
b. one mammogram, every 2 years, for a female Covered Person, ages 40-49, or more frequently, if recommended by a Practitioner, and
c. one mammogram, every year, for a female Covered Person ages 50 and older.

The following "Pre-Existing Conditions" and "Continuity of Coverage" provisions only apply to Policies issued to Employers of at least two but not more than five Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any *[*30*]* day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and DEPENDENT COVERAGE sections to determine if a Covered Person is a Late Enrollee. *The "Pre-Existing Conditions" provision does not apply to a Dependent who is an adopted child or

who is a child placed for adoption if the Employee enrolls the Dependent and agrees to make the required payments within [30] days after the Dependent's Eligibility Date.*

Pre-Existing Conditions

A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's coverage under this Policy starts, and for which:

a. a Covered Person sees a Practitioner, takes Prescribed Drugs, receives other medical care or treatment or had medical care or treatment recommended by a practitioner in the six months before his or her coverage starts; or

b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before his or her coverage starts.

A pregnancy which exists on the date a Covered Person's coverage starts is also a Pre-Existing Condition.

[Carrier] does not pay benefits for charges for Pre-Existing Conditions until the Covered Person has been continuously covered by this Policy for 180 days.

This limitation does not affect benefits for other unrelated conditions, or birth defects in a covered Dependent child. And [Carrier] waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under another [Carrier] group plan which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage

A new Covered Person may have been covered under a previous employer group health benefits plan prior to enrollment in this Policy. When this happens, [Carrier] gives credit for the time he or she was covered under the previous plan to determine if a condition is Pre-Existing. [Carrier] goes back to the date his or her coverage under the previous plan started. But the Employee's active Full-Time service with the Employer must start within 90 days of the date his or her coverage under the previous plan ended. And the person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the previous plan ends and the date his or her coverage under this Policy starts is Pre-Existing. [Carrier] does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Employer has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care

[Carrier] **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care, if such care is authorized as part of a home health care plan, coordinated by a Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services

Therapy Services mean the following services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

[Carrier] covers the Therapy Services listed below.

a. *Chelation Therapy*—means the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

b. *Chemotherapy*—the treatment of malignant disease by chemical or biological antineoplastic agents.

c. *Dialysis Treatment*—the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

d. *Radiation Therapy*—the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.

e. *Respiration Therapy*—the introduction of dry or moist gases into the lungs.

[Carrier] covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy*—the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, *[congenital anomaly]* or previous therapeutic process***; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly***.

g. *Speech Therapy*—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy*—treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living.

i. *Physical Therapy*—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.

Coverage*[s]* for Occupational Therapy and Physical Therapy, **combined,** is limited to 30 visits per Calendar Year.

j. *Infusion Therapy*—subject to [Carrier] Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. **Charges in connection with Infusion Therapy which are not Pre-Approved by [Carrier] are Non-Covered Charges.**

Preventive Care

[Carrier] covers charges for routine physical examinations including related laboratory tests and x-rays. [Carrier] also covers charges for immunizations and vaccines, well baby care, pap smears, mammography and screening tests. But [Carrier] limits what [Carrier] pays each Calendar Year to:

a. $500 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age 1, and

b. $300 per Covered Person for all other Covered Persons.

These changes are not subject to the Cash Deductibles or Co-Insurance.

Therapeutic Manipulation

[Carrier] limits what [Carrier] covers for *[spinal]* ***therapeutic*** manipulation to 30 visits per Calendar Year. And [Carrier] covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Mental and Nervous Conditions and Substance Abuse

[Carrier] limits what [Carrier] pays for the treatment of Mental and Nervous Conditions and Substance Abuse. [Carrier] includes *[an Illness]* ***a condition*** under this section if it manifests symptoms which are primarily mental and nervous, regardless of any underlying physical cause.

A Covered Person may receive treatment as an Inpatient in a Hospital or a Substance Abuse Center. He or she may also receive treatment as an Outpatient from a Hospital, Substance Abuse Center, or any properly licensed or certified Practitioner, psychologist or social worker. ***Covered charges for the treatment of Mental and Nervous conditions and Substance Abuse include charges incurred for Prescription Drugs.***

The Covered Person must pay the Co-Insurance shown on the Schedule for Covered Charges for such treatment. [Carrier] limits what [Carrier] pays each Calendar Year to $5,000.00 for combined Inpatient and Outpatient treatment. [Carrier] limits what [Carrier] pays Per Lifetime to $25,000.00 combined Inpatient and Outpatient benefit.

[Carrier] does not pay for Custodial Care, education, or training.

Transplant Benefits

[Carrier] covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a. Cornea
b. Kidney
c. Lung
d. Liver
e. Heart
f. Pancreas
g. Allogeneic Bone Marrow
h. Autologous Bone Marrow and Associated High Dose Chemotherapy **only** for treatment of:
   - Leukemia
   - Lymphoma
   - Neuroblastoma
   - Aplastic Anemia

- Genetic Disorders
  —SCID
  —WISCOT Alldrich

*[IMPORTANT NOTICE

This Policy has utilization review features. Under these features, [ABC—Systems, a health care review organization] reviews Hospital admissions and Surgery performed outside of a Practitioner's office [for Carrier]. These features must be complied with if a Covered Person:

a. is admitted as an Inpatient to a Hospital, or
b. is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

This Policy has alternate treatment features. Under these features, [DEF, a Case Coordinator] reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether alternative treatment may be available and appropriate. See the **Alternate Treatment Features** section for details.

This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom [Carrier] has entered into agreements. See the **Centers of Excellence Features** section for details.

What [Carrier] pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should [call The Group Claim Office at the number shown on his or her identification card.]

UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what [Carrier] will pay for Covered Charges. What [Carrier] pays is based on:

a. the Covered Charges actually incurred;
b. the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and
c. the Cash Deductible, Co-Payment and Co-Insurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of a Illness or Injury.

[Carrier] calls a Hospital admission or Surgery "emergency" if, after an evaluation of the Covered Person's condition, the attending Practitioner determines that failure to make the admission or perform the Surgery immediately would pose a serious threat to the Covered Person's life or health. A Hospital admission or Surgery made or performed for the convenience of Practitioners or patients is not an emergency.

By "covered professional charges for Surgery" [Carrier] means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means [Monday through Friday from 9 a.m. to 9 p.m. Eastern Time,] not including legal holidays.

Grievance Procedure

[If a Covered Person is not satisfied with a utilization review decision, the Covered Person or the Covered Person's Practitioner may appeal such decision by calling [ABC]. A Nurse reviewer will collect any additional medical information required and submit the case to a second [ABC] medical review physician. This physician will discuss the case with the physician reviewer who made the initial decision. The second medical review physician will then discuss the case with the Covered Person's Practitioner. The Covered Person's Practitioner is then notified of the appeal's recommendation and referred to the [Carrier] for any further appeals].

REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required

[Carrier] requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review

All non-emergency Hospital admissions must be reviewed by [ABC] before they occur. The Covered Person or the Covered Person's Practitioner must notify [ABC] and request a pre-hospital review. [ABC] must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify [ABC] and request a pre-hospital review at least [60 days] before the expected date of delivery, or as soon as reasonably possible.

When [ABC] receives the notice and request, [they] evaluate:

a. the Medical Necessity and Appropriateness of the Hospital admission
b. the anticipated length of stay and
c. the appropriateness of health care alternatives, like home health care or other out-patient care.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of their review. And [they] confirm the outcome of [their] review in writing.]

If [ABC] authorizes a Hospital admission, the authorization is valid for:

a. the specified Hospital;
b. the named attending Practitioner; and
c. the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by [ABC] again if:

a. he or she enters a Facility other than the specified Facility
b. he or she changes attending Practitioners; or
c. more than [60 days] elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission

[ABC] must be notified of all emergency admission by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day, or as soon as possible after the admission occurs.

When [ABC] is notified [by phone,] they require the following information:

a. the Covered Person's name, social security number and date of birth;
b. the Covered Person group plan number;
c. the reason for the admission;
d. the name and location of the Hospital;
e. when the admission occurred; and
f. the name of the Covered Person's Practitioner.

Continued Stay Review

The Covered Person or his or her Practitioner, must request a continued stay review for any emergency admission. This must be done at the time [ABC] is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

[ABC] also has the right to initiate a continued stay review of any Hospital admission. And [ABC] may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an emergency admission, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of the Hospital admission;
b. the anticipated length of stay; and
c. the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:

a. the Medical Necessity and Appropriateness of extending the authorized length of stay; and
b. the appropriateness of health care alternatives.

[ABC] notifies the Covered Person's Practitioner [by phone, of the outcome of the review. And [ABC] confirms the outcome of the review in writing.] The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance

In the case of a non-emergency Hospital admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges, **by 50%** if:

a. the Covered Person does not request a pre-hospital review; or
b. the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c. [ABC's] authorization becomes invalid and the Covered Person does not obtain a new one; or
d. [ABC] does not authorize the Hospital admission.

In the case of an emergency admission, as a penalty for non-compliance, [Carrier] reduces what it pays for covered Hospital charges **by 50%**, if:

a. [ABC] is not notified of the admission at the times and in the manner described above; or
b. the Covered Person does not request a continued stay review.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than [ABC] authorizes, [Carrier] reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends **by 50%** as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.

REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

[Carrier] requires a Covered Person to get a pre-surgical review for any non-emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section [Carrier] reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from [ABC]. [ABC] must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When [ABC] receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:

a. approve the proposed Surgery, or
b. require a second surgical opinion regarding the need for the Surgery.

[ABC] notifies the Covered Person's Practitioner, [by phone, of the outcome of the review. [ABC] also confirms the outcome of the review in writing.]

Required Second Surgical Opinion

If [ABC's] review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person must obtain a second surgical opinion in order to get full benefits under this Policy. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

[ABC] will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner on the list, or from a Practitioner of his or her own choosing, if the Practitioner:

a. is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b. is not a business associate of the Covered Person's Practitioner; and
c. does not perform the Surgery if it is needed.

[ABC] gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to [ABC].

[Carrier] covers charges for additional surgical opinions, including charges for related x-ray and tests. But what [Carrier] pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Co-Insurance.

Pre-Hospital Review

If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance

As a penalty for non-compliance, [Carrier] reduces what it pays for covered professional charges, for Surgery **by 50%** if:

a. the Covered Person does not request a pre-surgical review; or
b. [ABC] is not given at least 24 hours to review and evaluate the proposed Surgery; or
c. [ABC] requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done.
d. [ABC] does not confirm the need for Surgery.

But there is no penalty when the additional opinions do not confirm the need for the Surgery, and the Surgery is done anyway.

Penalties cannot be used to meet this Policy's:

a. Cash Deductible; or
b. Co-Insurance Caps.

ALTERNATE TREATMENT FEATURES

Important Notice: No Covered Person is required, in any way, to accept an Alternate Treatment Plan recommended by [DEF].

Definitions

"Alternate Treatment" means those services and supplies which meet both of the following tests:

a. They are determined, in advance, by [DEF] to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b. Benefits for charges incurred for the services and supplies would not otherwise be payable under this Policy.

"Catastrophic Illness or Injury" means one of the following:

a. head injury requiring an Inpatient stay
b. spinal cord Injury
c. severe burn over 20% or more of the body
d. multiple injuries due to an accident
e. premature birth
f. CVA or stroke
g. congenital defect which severely impairs a bodily function
h. brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i. terminal Illness, with a prognosis of death within 6 months
j. Acquired Immune Deficiency Syndrome (AIDS)
k. chemical dependency
l. mental, nervous and psychoneurotic disorders
m. any other Illness or Injury determined by [DEF] or [Carrier] to be catastrophic.

Alternate Treatment Plan

[DEF] will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, [DEF] will develop an Alternate Treatment Plan.

An Alternate Treatment Plan is a specific written document, developed by [DEF] through discussion and agreement with:

a. the Covered Person, or his or her legal guardian, if necessary;
b. the Covered Person's attending Practitioner; and
c. [Carrier].

The Alternate Treatment Plan includes:

a. treatment plan objectives;
b. course of treatment to accomplish the stated objectives;
c. the responsibility of each of the following parties in implementing the plan:
   - [DEF]
   - attending Practitioner
   - Covered Person
   - Covered Person's family, if any; and
d. estimated cost and savings.

If [Carrier], [DEF], the attending Practitioner, and the Covered Person agree [in writing,] on an Alternate Treatment Plan, the services and

supplies required in connection with such Alternate Treatment Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon alternate treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Alternate Treatment Plan will be considered in the accumulation of any Calendar Year and per lifetime maximums.

Exclusion

Alternate Treatment does not include services and supplies that [Carrier] determines to be Experimental or Investigational.

CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions

"Center of Excellence" means a Provider that has entered into an agreement with [Carrier] to provide health benefit services for specific procedures. The Centers of Excellence are [identified in the Listing of Centers of Excellence.]

"Pre-Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges

In order for charges to be Covered Charges, the Center of Excellence must:

a. perform a Pre-Screening Evaluation; and
b. determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be [subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.]]*

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and/or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***cosmetic surgery,*** except as otherwise stated in this Policy, unless it is required as a result of an ***Illness or*** Injury sustained while covered under this Policy or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances, except as otherwise stated in this Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's ***family:*** spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance ***fertility*** using artificial and surgical drugs and procedures, including, but not limited to, in vitro fertilization, in vivo fertilization or gamete-intrafallopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to ***Hearing aids *and* hearing *[examinations*** or fitting of]* ****exams*** **to determine the need for*** hearing aids ****or the need to adjust them****.

Services or supplies related to ***Herbal medicine.***

Care or treatment by means of ***high dose chemotherapy,*** except as otherwise stated in this Policy.

Services or supplies related to ***Hypnotism.***

Services or supplies because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit a felony.

Illness or ***Injury,*** including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to ***Marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services.***

Supplies related to ***Methadone*** maintenance.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate.

Non-prescription drugs or supplies, except insulin needles and syringes.

Services provided by a licensed ***pastoral counselor*** in the course of his or her normal duties as a religious.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private-Duty Nursing care,*** except as provided under the Home Health Care section of this Policy.

The amount of any charge which is greater than a ***Reasonable and Customary Charge.***

Services or supplies related to ***rest or convalescent cures.***

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; pre-marital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care.***

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker,*** except as otherwise stated in this Policy.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Covered Person would not have been charged if he or she did not have health care coverage;
d. provided by or in a government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Stand-by services required by a Provider.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in this Policy.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war,*** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug ***if such drug is*** used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUING RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): If a Covered Person is eligible to continue his or her group health benefits under both this Policy's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under both this Policy's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

While covered under more than one continuation section, the Covered Person:

a. will not be entitled to duplicate benefits; and
b. will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's *[plan]* *Policy*. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, *[and therefore]* *in which case*;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Policy during a continuation provided by this section is not qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the ***United States*** Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the *[Employee]* ***qualified continuee*** by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured

If an Employee dies while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Policy's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to [Carrier] on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the ***United States*** Social Security Act.
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Policy ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this policy's **Conversion Rights for Divorced Spouses** section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

***[Important Notice**

This section applies only to group health benefits. This section does not apply to any other coverages provided by this Policy.]*

If An Employee's Group Benefits End

If an Employee's health coverage ends due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner [Carrier] specifies.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Policy on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Policy on a regular basis. Any modifications made under this Policy will apply to similarly situated continuees. [Carrier] does not ask for proof of insurability in order for an Employee to continue.

When Continuation Ends

A Covered Person's continued health coverage ends on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Covered Person becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Covered Person becomes covered under another group *[medical]* ***health benefits*** plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Covered Person;
e. with respect to a Covered Person who becomes covered under another group *[medical]* ***health benefits*** plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Covered Person, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefits plan for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Policy.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

[Carrier] will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay [Carrier] on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, [Carrier].

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying.
b. the date the Covered Person becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Policy ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Policy.

AN EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's *[plan]* *Policy*. The Employee must contact his or her Employer to find out if:

- **the Employer must allow for a leave of absence under Federal law *[and, therefore]* *in which case;***
- **the section applies to the Employee.**

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her *[medical care]* ***group health benefits*** insurance will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-time work;
b. the end of a total ***leave*** period of 12 weeks in any 12 month period; *[or]*
c. the date on which the Employee's coverage would have ended had the Employee not been on leave***; or***
d. the end of the period for which the premium has been paid.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Policy may elect to continue coverage. Subject to the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Policy.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

IF AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health *[coverage]* ***benefits*** for his or her former spouse ends. The former spouse may convert to an individual major medical policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Policy on the date the group health *[coverage]* ***benefits*** ends. See **exceptions** below.

Exceptions

No former spouse may use this conversion right:

[● unless he or she has been insured under this Policy for at least 3 months;]
*[●]***a.*** if he or she is eligible for Medicare; or
*[●]***b.*** if it would cause him or her to be overinsured.

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. [Carrier] will determine if overinsurance exists using its standards for overinsurance.

HOW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health *[coverage]* ***benefits*** ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED POLICY

The individual policy will provide the major medical benefits that [Carrier] is required to offer in the state where the Employer is located.

The individual policy will take effect on the day after group health *[coverage]* ***benefits*** under this Policy ends.

After group health *[coverage]* ***benefits*** under this Policy ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Policy. If so, benefits to be paid under the individual policy will be reduced by the amount paid under this Policy.

EFFECT OF INTERACTION WITH A HEALTH MAINTENANCE ORGANIZATION PLAN

HEALTH MAINTENANCE ORGANIZATION ("HMO") means a prepaid alternative health care delivery system.

A Policyholder may offer its Employees HMO membership in lieu of the *[medical care benefits]* ***group health benefits insurance*** provided by this Policy. If the Employer does, the following provisions apply.

IF AN INSURED EMPLOYEE ELECTS HMO MEMBERSHIP

Date *[Medical Care]* *Group Health Benefits* Insurance Ends

Insurance for an Employee and his or her Dependents will end on the date the Employee becomes an HMO member.

Benefits After *[Medical Care]* *Group Health Benefits* Insurance Ends

When an Employee becomes an HMO member, the **Extended Health Benefits** section of this Policy will not apply to him or her and his or her Dependents.

Exception:

IF: on the date membership takes effect, the HMO does not provide benefits due to:

- an HMO waiting period
- an HMO Pre-Existing Conditions limit, or
- a confinement in a Hospital not affiliated with the HMO

AND the HMO provides benefits for total disability when membership ends

THEN *[medical care]* ***group health*** benefits will be paid until the first of the following occurs:

- 90 days expire from the date membership takes effect
- the HMO's waiting period ends
- the HMO's Pre-Existing Conditions limit expires, or
- hospitalization ends.

IF AN HMO MEMBER ELECTS *[MEDICAL CARE]* *GROUP HEALTH BENEFITS* INSURANCE PROVIDED BY THIS POLICY

Date Transfer To Such Insurance Takes Effect

Each Employee who is an HMO member may transfer to such insurance by written request. If he or she elects to do so, any Dependents who are HMO members must also be included in such request. The date such persons are to be insured depends on when and why the transfer request is made.

request made during an open enrollment period

[Carrier] and the Policyholder will agree when this period will be. If an Employee requests insurance during this period, he or she and his or her Dependents will be insured on the date such period ends.

request made because:

- **an HMO ends its operations**
- **Employee moves outside the HMO service area**

If an Employee requests insurance because membership ends for these reasons, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- on or before the date membership ends, they will be insured on the date such membership ends
- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made because an HMO becomes insolvent

If an Employee requests insurance because membership ends for this reason, the date he or she and his or her Dependents are to be insured depends on the date the request is made.

If it is made:

- within 31 days after the date membership ends, they will be insured on the date the request is made
- more than 31 days after the date membership ends, the Employee and his or her Dependents will be Late Enrollees.

request made at any other time

An Employee may request insurance at any time other than that described above. In this case, he or she and his or her Dependents will be Late Enrollees.

Other Provisions Affected By A Transfer

If a person makes a transfer, the following provisions, if required by this Policy for such insurance, will not apply on the transfer date:

- an Actively at Work requirement
- non-confinement, or similar requirement
- a waiting period, or
- Pre-Existing Conditions provisions.

Charges not covered

Charges incurred before a person becomes insured will *[not]* be considered Non-Covered Charges.

Maximum benefit

The total amount of benefits to be paid for each person will be the maximum benefit specified in this policy, regardless of any interruption in such person's insurance under this Policy.

Right to change premium rates

[Carrier] has the right to change premium rates when, in its opinion, its liability under this Policy is changed by interaction with an HMO plan.

COORDINATION OF BENEFITS

***[Important Notice**

This provision applies to all health expense benefits under this Policy. It does not apply to death, dismemberment, or loss of income benefits.]*

Purpose Of This Provision

[An Employee] ***A Covered Person*** may be covered for health *[expense]* benefits by more than one plan. For instance, he or she may be covered by this Policy as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, the provision allows [Carrier] to coordinate what [Carrier] pays with what another plan pays. [Carrier] does this so the Covered Person does not collect more in benefits than he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expenses or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
*[e. group or group-type hospital indemnity benefits which exceed $150.00 per day.

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of $150.00 per day or less; and]*
d. any plan [Carrier] says [Carrier] supplements, as named in the Schedule.

"This plan" means the part of [Carriers] group plan subject to this provision.

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a member or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, [Carrier] views the reasonable cash value of each service as an allowable expense and as a benefit paid. [Carrier] also views items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a member's or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefits is less than or equal to the reduction that would have been made under the terms of this Plan if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the member or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a member or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

[Carrier] applies provision when a member or Dependent is covered by more than one plan. When this happens [Carrier] will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan

have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a member pays first; the plan that covers a person as a Dependent pays second.
b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorce parents, the following governs which plan pay*s* first when the person is a Dependent of a member:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a member whose birthday falls later in the Calendar Year pays second. The member's year of birth is ignored.

But, if the plan that [Carrier] is coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a member.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when [Carrier] applies this provision, [Carrier] pay less than [Carrier] would otherwise pay, [Carrier] apply only that reduced amount against payment limits of this plan.

[Carrier's] Right To Certain Information

In order to coordinate benefits, [Carrier] needs certain information. An Employee must supply [Carrier] with as much of that information as he or she can. But if he or she cannot give [Carrier] all the information [Carrier] needs, [Carrier] has the right to get this information from any source. And if another insurer needs information to apply its coordination provision, [Carrier] has the right to give that insurer such information. If [Carrier] gives or get information under this section [Carrier] cannot be held liable for such action.

When payment that should have been made by this plan have been made by another plan, [Carrier] has the right to repay that plan. If [Carrier] does so, [Carrier] is no longer liable for that amount. And if [Carrier] pays out more than [Carrier] should have, [Carrier] has the right to recover the excess payment.

Small Claims Waiver

[Carrier] does not coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 [Carrier] will count the entire amount of the claim when [Carrier] coordinates.

BENEFITS FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's benefits under this Policy when expenses are incurred as a result of an automobile related injury.

Definitions

"Automobile Related Injury" means bodily injury sustained by a Covered Person as a result of an accident.

a. while occupying, entering, leaving or using an automobile; or
b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Policy;
b. PIP; or
c. OSAIC.

"Eligible Expense" means that portion of expense incurred for treatment of an Injury which is covered under this Policy without applicaiton of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Policy provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Covered Person under this Policy. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Policy may be primary for One Covered Person, but not for another if the person has separate automobile policies and have made different selections regarding primacy of health coverage.

This Policy is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Policy will be primary.

If there is a dispute as to which policy is primary, this Policy will pay benefits as if it were primary.

Benefits this Policy will pay if it is primary to PIP or OSAIC.

If this Policy is primary to PIP or OSAIC it will pay benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Policy will apply if:

- the Covered Person is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Policy will pay if it is secondary to PIP or OSAIC.

If this Policy is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payments, or
b. the benefits that would have been paid if this Policy had been primary.

Medicare

If this Policy supplements coverage under Medicare it can be primary to automobile insurance only to the extent that Medicare is primary to automobile insurance.

[HOW THIS POLICY INTERACTS WITH]* MEDICARE *AS SECONDARY PAYOR

IMPORTANT NOTICE

***[The following section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:**

- **the Employer is subject to the How This Plan Interacts with Medicare section and therefore;**
- **the section applies to the Employee]***

***The following sections regarding Medicare may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if the Employer is subject to Medicare as Secondary Payor rules.**

If the Employer is subject to such rules, this Medicare as Secondary Payor section applies to the Employee.

If the Employer is NOT subject to such rules, this Medicare as Secondary Payor section does not apply to the Employee, in which case, Medicare will be the primary health plan and this Policy will be the secondary health plan for Covered Persons who are eligible for Medicare.*

The following provisions explain how this *[plan's]* ***Policy's*** group health benefits interact with the benefits available under Medicare ***as Secondary Payor rules***. A Covered Person may be eligible for Medicare by reason of age, disability, or End Stage Renal Disease. Different rules apply to each type of Medicare eligibility, as *[shown]* ***explained*** below.

With respect to the following provisions:

a. "Medicare" when used above, means Part A and B of the health care program for the aged and disabled provided by Title XVII of the ***United States*** Social Security Act, as amended from time to time.

b. A Covered Person is considered to be eligible for Medicare by reason of age from the first day of the month during which he or she reaches age 65. However, if the Covered Person is born on the first day of a month, he or she is considered to be eligible for Medicare from the first day of the month which is immediately prior to his or her 65th birthday.

c. A "primary" health plan pays benefits for a Covered Person's Covered Charge first, ignoring what the Covered Person's "secondary" plan pays. A "secondary" health plan then pays the remaining unpaid allowable expenses. See the **Coordination of Benefits** section for a definition of "allowable expense".

[d. "We" means Carrier]

MEDICARE ELIGIBILITY BY REASON OF AGE

Applicability

This section applies to an Employee or his or her insured spouse who is eligible for Medicare by reason of age.

Under this section, such an Employee or insured spouse is referred to as a "Medicare eligible."

This section does not apply to:

a. a Covered Person, other than an Employee or insured spouse

b. an Employee or insured spouse who is under age 65, or

c. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When An Employee or Insured Spouse Becomes Eligible For Medicare

When an Employee or insured spouse becomes eligible for Medicare by reason of age, he or she must choose one of the two options below.

Option A—The Medicare eligible may choose this Policy as his or her primary health plan. If he or she does, Medicare will be his or her secondary health plan. See the **When This Policy is Primary** section below, for details.

Option B—The Medicare eligible may choose Medicare as his or her primary health plan. If he or she does, group health benefits under this Policy will end. See the **When Medicare is Primary** section below, for details.

If the Medicare eligible fails to choose either option when he or she becomes eligible for Medicare by reason of age, [Carrier] will pay benefits as if he or she had chosen Option (A).

When this Policy is primary

When a Medicare eligible chooses this Policy as his or her primary health plan, if he or she incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

When Medicare is primary

If a Medicare eligible chooses Medicare as his or her primary health plan, he or she will no longer be covered for such benefits by this Policy. Coverage under this Policy will end on the date the Medicare eligible elects Medicare as his or her primary health plan.

A Medicare eligible who elects Medicare as his or her primary health plan, may later change such election, and choose this Policy as his or her primary health plan.

MEDICARE ELIGIBILITY BY REASON OF DISABILITY

Applicability

This section applies to a Covered Person who is:

a. under age 65; and

b. eligible for Medicare by reason of *[End Stage Renal Disease]* ***disability***.

Under this section, such Covered Person is referred to as a "disabled Medicare eligible".

This section does not apply to:

a. a Covered Person who is eligible for Medicare by reason of age; or

b. a Covered Person who is eligible for Medicare solely on the basis of End Stage Renal Disease.

When A Covered Person Becomes Eligible For Medicare

When a Covered Person becomes eligible for Medicare by reason of disability, ***Medicare is the primary plan.*** *[this]* ***This*** Policy *[supplements the benefit provided by Medicare]* ***is the secondary plan***.

[If the disabled Medicare incurs a Covered Charge for which benefits are payable under both this Policy and Medicare, [Carrier] subtracts what Medicare pays from what [Carrier] normally pays.]

If a Covered Person is eligible for Medicare by reason of disability, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

Applicability

This section applies to a Covered Person who is eligible for Medicare *[solely]* on the basis of End Stage Renal Disease (ESRD).

Under this section, such Covered Person is referred to as a "ESRD Medicare eligible".

This section does not apply to a Covered Person who is eligible for Medicare by reason of disability.

When A Covered Person Becomes Eligible For Medicare Due to ESRD

When a Covered Person becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 18 consecutive months, if he or she incurs a charge for the treatment of ESRD for which benefits are payable under both this Policy and Medicare, this Policy is considered primary. This Policy pays first, ignoring Medicare. Medicare is considered the secondary plan.

This 18 month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and

b. with respect to a ESRD Medicare eligible who receives a kidney transplant, the first day of the month during which such Covered Person becomes eligible for Medicare.

After the 18 month period described above ends, if an ESRD Medicare eligible incurs a charge for which benefits are payable under both this Policy and Medicare, *[[Carrier] supplements what]* Medicare *[pays]* ***is the primary plan. This Policy is the secondary plan***. *[[Carrier] subtracts what Medicare pays from what [Carrier] normally pays.]* If a Covered Person is eligible for Medicare *[solely]* on the basis of ESRD, he or she must be covered by both Parts A and B. If he or she is not, he or she must meet the Medicare Alternate Deductible shown in the Schedule.

RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Policy.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than [Carrier], the Employer or the Covered Person.

If a Covered Person makes a claim to [Carrier] for benefits under this Policy prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay [Carrier] from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

[Carrier] shall require the return of health benefits paid for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;

b. a satisfied judgment; or

c. other means.

[Carrier] will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which [Carrier] has paid benefits.

The repayment will be equal to the amount of benefits paid by [Carrier]. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to [Carrier].

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

[Carrier] will not pay any benefits under this Policy to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

STATEMENT OF ERISA RIGHTS

As a participant, an Employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

a. Examine, with charge, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The document may be examined at the Plan Administrator's office and at other specified locations such as worksites and union halls.
b. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
c. Receive a summary of the plan's annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for plan participants, ERISA imposes duties upon the people called "Fiduciaries", who are responsible for the operation of the Employee benefits plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. An Employer may not fire the Employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an Employees' claim for welfare benefits is denied in whole or in part, he or she must receive a written explanation of the reason for the denial. The Employee has the right to have his or her claim reviewed and reconsidered.

Under ERISA, there are steps an Employee can take to enforce the above rights. For instance, the Employee may file suit in a federal court if he or she requests materials from the plan and does not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay the Employee, up to $100.00 a day until he or she receives them (unless the materials were not sent because of reasons beyond the administrator's control). If his or her claim for benefit is denied in whole or in part, or ignored, he or she may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against him or her for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If he or she is successful, the court may order the person the Employee has sued to pay court costs and legal fees. If he or she loses, the court may order him or her to pay, for example, if it finds his or her claim is frivolous. If the Employee has any question about his or her plan, he or she should contact the Plan Administrator. If he or she has any questions about this statement or about his or her rights under ERISA he or she should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

CLAIMS PROCEDURE

Claim forms and instructions for filing claims may be obtained from the Plan Administrator. Completed claim forms and any other required material should be returned to the Plan Administrator for submission to [Carrier].

[Carrier] is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in the Employee's certificate, [Carrier] will also observe the procedures listed below. All notifications from [Carrier] will be in writing.

a. If a claim is wholly or partially denied, the claimant will be notified of the decision within 45 days after [Carrier] received the claim.
b. If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which [Carrier] expects to render the final decision.
c. If a claim is denied, [Carrier] will provide the Plan Administrator, for delivery to the claimant, a notice that will set forth:
   - the specific reason(s) the claim is denied;
   - specific references to the pertinent plan provision on which the denial is based;
   - a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
   - and explanation of the plan's claim review procedure.

A claimant must file a request review of a denied claim within 60 days after receipt of written notification of denial of a claim.

d. [Carrier] will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing. [Carrier] will render a decision as soon as possible, but no later than 120 days after receiving the request. [Carrier] will notify the claimant about the extension.

The above procedures are required under the provisions of ERISA.

EXHIBIT G

HMO PLAN

[Carrier]

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION CONTRACT

CONTRACT HOLDER: [ABC Company]

GROUP CONTRACT NUMBER
[G-12345]

GOVERNING JURISDICTION
NEW JERSEY

EFFECTIVE DATE OF CONTRACT
[January 1, 1994]

CONTRACT ANNIVERSARIES: [January 1st of each year, beginning in 1995.]

PREMIUM DUE DATES: [Effective Date, and the first day of the month beginning with February, 1994.]

AFFILIATED COMPANIES: [DEF Company]

[Carrier], in consideration of the application for this Contract and of the payment of premiums as stated herein, agrees to arrange [or provide] services ***and supplies*** in accordance with and subject to the terms of this Contract. This Contract is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages constitute this Contract.

The Effective Date is specified above.

This Contract takes effect on the Effective Date, if it is duly attested below. It continues as long as the required premiums are paid, unless it ends as described in its General Provisions.

[Secretary President]

TABLE OF CONTENTS

Section		Page
I.	SCHEDULE OF PREMIUM RATES	
II.	SCHEDULE OF SERVICES *[& BENEFITS]*	
III.	DEFINITIONS	
IV.	ELIGIBILITY	
V.	COVERED SERVICES AND SUPPLIES	
VI.	NON-COVERED SERVICES AND SUPPLIES	
VII.	GRIEVANCE PROCEDURE	
VIII.	COORDINATION OF BENEFITS ***AND SERVICES***	
IX.	CONTRACT HOLDER GENERAL PROVISIONS	
X.	MEMBER GENERAL PROVISIONS	
XI.	CONTINUATION PROVISIONS	
XII.	RIGHT OF RECOVERY	
XIII.	EFFECT OF MEDICARE ON THE COVERAGE	

I. SCHEDULE OF PREMIUM RATES

[The monthly premium rates, in U.S. dollars, for the coverage provided under this Contract are:

Subscriber Only..... $

Subscriber and Spouse..... $

Subscriber and Child(ren)..... $

Subscriber and Family..... $

(including Subscriber, spouse and one or more eligible dependents)]

We have the right to change any Premium rate set forth above at the times and in the manner established by the provision of this Contract entitled "Contract Holder General Provisions."

II. SCHEDULE OF SERVICES *[& BENEFITS]*

***[BENEFITS FOR COVERED]* *THE* SERVICES OR SUPPLIES *COVERED* UNDER THIS CONTRACT ARE SUBJECT TO ALL COPAYMENTS [AND COINSURANCE] AND ARE DETERMINED PER CALENDAR YEAR PER MEMBER, UNLESS OTHERWISE STATED. MAXIMUMS ONLY APPLY TO THE SPECIFIC SERVICES PROVIDED.**

[*SERVICES ___* COPAYMENTS *[/COINSURANCE]*:

HOSPITAL SERVICES:

INPATIENT
$150 Copayment/day for a maximum of 5 days/admission. Maximum Copayment $1,500/Calendar Year. Unlimited days.

OUTPATIENT
$15 Copayment/visit

DOCTOR SERVICES *RECEIVED AT A HOSPITAL*:

INPATIENT
None

OUTPATIENT
$15 Copayment/visit; no Copayment if any other Copayment applies.

EMERGENCY ROOM
$50 Copayment/visit/Member (credited toward Inpatient Admission if Admission occurs within 24 hours as a result of the same or related illness or Injury for which the person visited the Emergency Room)

OUTPATIENT SURGERY
$15 Copayment/visit.

HOME HEALTH CARE
Unlimited days, if preapproved.

HOSPICE *[CHARGES]* *SERVICES*
Unlimited days, if preapproved.

MATERNITY (PRE-NATAL CARE)
$25 Copayment for initial visit only.

MENTAL NERVOUS CONDITIONS AND SUBSTANCE ABUSE:

OUTPATIENT
$15 Copayment/visit; maximum 20 visits/Calendar Year.

INPATIENT
$150 Copayment/day for a maximum of 5 days per admission. Maximum Copayment $1,500/Calendar Year.
Maximum of 30 days inpatient care/Calendar Year. One Inpatient day may be exchanged for two Outpatient visits.

PODIATRIC
$15 Copayment/visit (excludes Routine Foot Care).

PRE-ADMISSION TESTING
$15 Copayment/visit.

PRESCRIPTION DRUG
50% Coinsurance [May be substituted by Carrier with $15 Copayment.]

PRIMARY CARE PHYSICIAN [OR CARE MANAGER] SERVICES
$15 Copayment/visit.

PRIMARY CARE SERVICES
$15 Copayment/visit.

***REHABILITATION SERVICES**
Subject to the Inpatient Hospital Services Copayment above. The Copayment does not apply if Admission is immediately preceeded by a Hospital Inpatient Stay.*

SECOND SURGICAL OPINION
$15 Copayment/visit.

SPECIALIST SERVICES
$15 Copayment/visit.

SKILLED NURSING CENTER
Unlimited days, if preapproved.

THERAPY SERVICES
$15 Copayment/visit.

***[X-RAY & LAB]* *DIAGNOSTIC SERVICES* (OUTPATIENT)**
$15 Copayment/visit.

NOTE: NO *[BENEFITS]* *SERVICES OR SUPPLIES* WILL BE PROVIDED IF A MEMBER FAILS TO OBTAIN PRE-AUTHORIZATION OF CARE THROUGH HIS OR HER PRIMARY CARE PHYSICIAN. READ THE GENERAL PROVISIONS CAREFULLY BEFORE OBTAINING MEDICAL CARE, SERVICES OR SUPPLIES.

REFER TO THE SECTION OF THIS CONTRACT CALLED "NON-COVERED SERVICES AND SUPPLIES" TO SEE WHAT *THE* SERVICES AND SUPPLIES ARE *FOR WHICH A MEMBER IS* NOT ELIGIBLE *[FOR BENEFITS]*.

III. DEFINITIONS

The words shown below have specific meanings when used in this Contract. Please read these definitions carefully. Throughout the Contract, these defined terms appear with their initial letters capitalized. They will help Members understand what services are provided.

[ACTIVELY AT WORK or ACTIVE WORK. Performing, doing, participating or similarly functioning in a manner usual for the task for full pay, at the Employer's place of business, or at any other place that the Employer's business requires the Employee to go.]

ALCOHOL ABUSE. Abuse of or addiction of alcohol.

AMBULANCE. A certified transportation vehicle for transporting Ill or Injured people that contains all life-saving equipment and staff as required by applicable state and local law.

ANNIVERSARY DATE. The date which is one year from the Effective Date of this Contract and each succeeding yearly date thereafter.

AFFILIATED COMPANY. A corporation or other business entity affiliated with the Contract Holder through common ownership of stock or assets.

BOARD. The Board of Directors of the New Jersey Small Employer Health Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

[CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.]

[COINSURANCE. The percentage of Covered Services or Supplies that must be paid by a Member. Coinsurance does not include Copayments.]

CONTRACT. This contract, including the application and any riders, amendments or endorsements, between the Employer and [Carrier].

CONTRACT HOLDER. Employer or organization which purchased this Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the "Covered Services and Supplies" section of this Contract.

Read the entire Contract to find out what We limit or exclude.

CUSTODIAL CARE. Any service or supply, including room and board, which:

a. is furnished mainly to help Member meet Member's routine daily needs; or
b. can be furnished by someone who has no professional health care training or skills.

DEPENDENT.

An Employee's:

a. legal spouse;
b. unmarried Dependent child who is under age 19; and
c. *[his or her]* unmarried Dependent child from age 19 until his or her 23rd birthday, who is enrolled as a full-time student at an accredited school. ***We can require periodic proof of a Dependent child's status as a full-time student.***

Under certain circumstances, an incapacitated child is also a Dependent. See the Eligibility section of this Contract.

An Employee's "unmarried Dependent child" includes his or her legally adopted child, his or her step-child if such step child depends on the Employee for most of his or her support and maintenance and children under a court appointed guardianship. We treat a child as legally adopted from the time the child is placed in the home for purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in any armed force.

A Dependent is not a person who is insured by this Contract as an Employee.

At Our discretion, We can require proof that a person meets the definition of a Dependent.

***DEPENDENT'S ELIGIBILITY DATE.**

The later of:

a. the Employee's Eligibility Date; or
b. the date the person first becomes a Dependent.*

DIAGNOSTIC SERVICES. Procedures ordered by a recognized Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:

a. radiology, ultrasound, and nuclear medicine;
b. laboratory and pathology; and
c. EKG's, EEG's, and other electronic diagnostic tests.

DISCRETION. Our sole right to make a decision or determination.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

a. designed and able to withstand repeated use;
b. used primarily and customarily for a medical purpose;
c. is generally not useful to a Member in the absence of an Illness or Injury; and
d. suitable for use in the home.

Durable Medical Equipment includes, but is not limited to, apnea monitors, breathing equipment, hospital-type beds, walkers, and wheelchairs.

Among other things, Durable Medical Equipment does not include: adjustments made to vehicles, air conditioners, air purifiers, humidifiers, dehumidifiers, elevators, ramps, stair glides, Emergency Alert equipment, handrails, heat appliances, improvements made to a Member's home or place of business, waterbeds, whirlpool baths, exercise and massage equipment.

EFFECTIVE DATE. The date on which coverage begins under this Contract for the Employer, *[to]* ***or*** the date coverage begins under this Contract for a Member, as the context in which the term is used suggests.

EMPLOYEE. A Full-Time Employee (25 hours per week) of the Employer. Partners, Proprietors, and independent contractors will be treated like Employees, if they meet all of this Contract's conditions of eligibility.

***EMPLOYEE'S ELIGIBILITY DATE.**

a. the date of employment; or
b. the day after any applicable waiting period ends.*

EMPLOYER. [ABC Company].

EXPERIMENTAL or INVESTIGATIONAL.

Services or supplies which We Determine are:

a. not of proven benefit for the particular diagnosis or treatment of a Member's particular condition; or
b. not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of a Member's particular condition; or
c. provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

Unless otherwise required by law with respect to drugs which have been prescribed for the treatment of a type of cancer for which the drug has not been approved by the United States Food and Drug Administration (FDA), We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalizations in connection with Experimental or Investigational services or supplies.

We will also not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of a Member's particular condition.

Governmental approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of a Member's particular condition.

We will apply the following five criteria in Determining whether services or supplies are Experimental or Investigational:

1. any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition *[may require that any or all of the five criteria be met]*;
2. conclusive evidence from the published peer-reviewed medical literature must exist that the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale;
3. demonstrated evidence as reflected in the published peer-reviewed medical literature must exist that over time the technology leads to improvement in health outcomes, i.e., the beneficial effects outweigh any harmful effects;
4. proof as reflected in the published peer-reviewed medical literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable; and
5. proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph 3, is possible in standard conditions of medical practice, outside clinical investigatory settings.

FULL-TIME. A normal work week of 25 or more hours. Work must be at the Employer's regular place of business or at another place to which an Employee must travel to perform his or her regular duties for his or her full and normal work hours.

*[[**GENERIC DRUG.** An equivalent prescription drug containing the same active ingredients as a brand name prescription drug but costing less. The equivalent must be identical in strength and form as required by the FDA.]]*

GOVERNMENT HOSPITAL. A Hospital operated by a government or any of its subdivisions or agencies, including, but not limited to, a Federal, military, state, county or city Hospital.

[HEALTH CARE CENTER OR HEALTH CENTER. A place operated by or on behalf of an HMO where [Network] [Participating] Providers provide Covered Services and Supplies to Members.]

HOME HEALTH AGENCY. A Provider which *[mainly]* provides Skilled Nursing Care for Ill or Injured people in their home under a home health care program designed to eliminate Hospital stays. It must be licensed by the state in which it operates, or it must be certified to participate in Medicare as a Home Health Agency.

HOSPICE. A *[facility]* ***Provider*** which *[mainly]* provides palliative and supportive care for Terminally Ill or Injured people who are terminally injured. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be approved for its stated purpose by Medicare; or
b. be accredited for its stated purpose by either the Joint Commission or the National Hospice Organization.

HOSPITAL. A facility which mainly provides Inpatient care for Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be accredited as a hospital by the Joint Commission, or
b. be approved as a Hospital by Medicare.

Among other things, a Hospital is not a convalescent, rest or nursing home or facility, or a facility, or part of it, which mainly provides Custodial Care, educational care or rehabilitative care. A facility for the aged or substance abusers is not a Hospital.

ILLNESS. A sickness or disease suffered by a Member. A Mental or Nervous Condition is not an illness.

INITIAL DEPENDENT. Those eligible Dependents an Employee has at the time he or she first becomes eligible for Employee coverage. If at the time the Employee does not have any eligible Dependents, but later acquires them, the first eligible Dependents he or she acquires are his or her Initial Dependents.

INJURY. Damage to a Member's body due to accident, and all complications arising from that damage.

INPATIENT. Member if physically confined as a registered bed patient in a Hospital or other recognized health care facility; or services and supplies provided in such a setting.

JOINT COMMISSION. The Joint Commission on the Accreditation of Health Care Facilities.

LATE ENROLLEE. An eligible Employee or Dependent who requests enrollment under this Contract more than ***[*30*]*** days after first becoming eligible. However, an eligible Employee or Dependent will not be considered a Late Enrollee under certain circumstances. See the **Employee Coverage** and **Dependent Coverage** sections of this Contract.

MEDICAL EMERGENCY. The sudden, unexpected onset, due to Illness or Injury, of a medical condition that is expected to result in either a threat to life or to an organ, or a body part not returning to full function. ***Examples of Medical Emergencies include but are not limited to*** *[Heart]* ***heart*** attacks, strokes, convulsions, serious burns, obvious bone fractures, wounds requiring sutures, poisoning, and loss of consciousness *[are Medical Emergencies]*.

A near-term delivery is not a Medical Emergency.

MEDICALLY NECESSARY AND APPROPRIATE. Services or supplies provided by a recognized health care Provider that We Determine to be:

a. necessary for the symptoms and diagnosis or treatment of the condition, Illness or Injury;
b. provided for the diagnosis or the direct care and treatment of the condition, Illness or Injury;
c. in accordance with ***generally*** accepted medical *[standards in the community at the time]* ***practice***;
d. not for a Member's convenience;
e. the most appropriate level of medical care that a Member needs; ***and***
[f. accepted by a professional medical society in the United States as beneficial for the control or cure of the Illness or Injury being treated; and]
*[g.]***f.*** furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of a Medical Emergency, the fact that *[an attending doctor]* ***a Non-participating Provider*** prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the ***United States*** Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the Health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under this Contract (includes Subscriber/covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:

a. accredited for its stated purpose by the Joint Commission; *[or]*
b. approved for its stated purpose by Medicare***; or***
c. accredited or licensed by the State of New Jersey to provide mental health services*.

MENTAL OR NERVOUS CONDITION. A condition which manifests symptoms which are primarily mental or nervous, regardless of any underlying physical cause. A Mental and Nervous Condition includes, but is not limited to, psychoses, neurotic and anxiety disorders, schizophrenic disorders, affective disorders, personally disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

In Determining whether or not a particular condition is a Mental and Nervous Condition, We may refer to the current edition of the Diagnostic and Statistical manual of Mental Conditions of the American Psychiatric Association.

[NETWORK] [PARTICIPATING] PROVIDER. A Provider which has an agreement [directly or indirectly] with Us [or Our associated medical groups] to provide Covered Services or Supplies.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

NON-COVERED SERVICES. Services or supplies which are not included within Our definition of Covered Services or Supplies, ***are included in the list of Non-covered Services and Supplies,*** or which exceed any of the *[benefit limits]* ***limitations*** shown in this Contract.

NON-[NETWORK] [-PARTICIPATING] PROVIDER. A Provider which is not a [Network] [Participating] Provider.

NURSE. A registered nurse or licensed practical nurse, including a nursing specialist such as a nurse mid-wife or nurse anesthetist, who:

a. is properly licensed or certified to provide medical care under the laws of the state where the nurse practices; and
b. provides medical services which are within the scope of the nurse's license or certificate and are covered by this Contract.

OUTPATIENT. Member if registered at a Practitioner's office or recognized health care facility and not an Inpatient; or services and supplies provided in such a setting.

PERIOD OF CONFINEMENT. Consecutive days of Inpatient services provided to an Inpatient, or successive Inpatient confinements due to the same or related causes, when discharge and re-admission to a recognized facility occurs within 90 days or less. We Determine if the cause(s) of the confinements are the same or related.

PRACTITIONER. A medical practitioner who:

a. is properly licensed or certified to provide medical care under the laws of the state where the practitioner practices; and
b. provides medical services which are within the scope of the practitioner's license or certificate and which are covered by this Contract.

[PRE-EXISTING CONDITION. An Illness or Injury which manifests itself in the six months before a Member's coverage under this Contract starts, and for which:

a. A Member sees a doctor, takes prescribed drugs, receives other medical care or treatment or had medical care or treatment recommended by a Practitioner in the six months before the Member's coverage starts; or
b. an ordinarily prudent person would have sought medical advice, care or treatment in the six months before the person's coverage starts.

A pregnancy which exists on the date a Member's coverage starts is also a Pre-Existing Condition.

See the Non-Covered Services and Supplies section of this Contract for details on how this Contract limits the services for Pre-Existing Conditions.]

PRESCRIPTION DRUGS. Drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution—Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as Determined by Us, such as insulin.

PRIMARY CARE PHYSICIAN (PCP). A [Network] [Participating] Provider who is a doctor specializing in family practice, general practice, internal medicine, [obstetrics/gynecology (for *[OB/GYN services only]* ***pre and post-natal care, birth and treatment of the diseases and hygiene of females***),] or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PROVIDER. A recognized facility or practitioner of health care.

REASONABLE and CUSTOMARY. An amount that is not more than the usual or customary charge for the service or supply as We determined

based on a standard approved by the Board. *[When We decide what is reasonable, We look at the Member's condition and how severe it is. We also look at special circumstances.]* The Board will decide a standard for what is Reasonable and Customary under this Contract. The chosen standard is an amount which is most often charged for a given service by a Provider *[within the range of usual fees charged by most Providers of similar training and experience for the same service]* within the same geographic area.

REFERRAL. Specific direction or instruction from A Member's Primary Care Physician in conformance with our policies and procedures that directs a Member to a facility or Provider for health care.

REHABILITATION CENTER. A facility which mainly provides therapeutic and restorative services to Ill or Injured people. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Facilities; or
b. be approved for its stated purpose by Medicare.

ROUTINE FOOT CARE. The cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis, tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, foot orthotics and supportive devices for the foot.

SERVICE AREA. A geographic area We defined by [ZIP codes] [county].

SKILLED NURSING CARE. Services which are more intensive than Custodial Care, are provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), and require the technical skills and professional training of an R.N. or L.P.N.

SKILLED NURSING CENTER. A facility which mainly provides full-time Skilled Nursing Care for Ill or Injured people who do not need to be in a Hospital. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be accredited for its stated purpose by the Joint Commission; or
b. be approved for its stated purpose by Medicare.

SMALL EMPLOYER. Any person, firm, corporation, partnership or association actively engaged in business which, on at least 50% of its working days during the preceding Calendar Year quarter, employed at least two, but no more than 49 eligible Employees, the majority of whom are employed within the State of New Jersey. In determining the number of eligible Employees, all Affiliated Companies will be considered as one Employer.

SPECIALIST DOCTOR. A doctor who provides medical care in any generally accepted medical or surgical specialty or subspecialty.

SPECIALIST SERVICES. Medical care in specialties other than family practice, general practice, internal medicine [or pediatrics] [or obstetrics/gynecology (for *[OB/GYN services only]* ***routine pre and post-natal care, birth and treatment of the diseases and hygiene of females****)].

SUBSCRIBER. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom *[Premium]* ***premium*** has been received.

SUBSTANCE ABUSE. Abuse of or addiction to drugs.

SUBSTANCE ABUSE CENTER. A facility that mainly provides treatment for people with Substance Abuse problems. It must carry out its stated purpose under all relevant state and local laws, and it must either:

a. be accredited for its stated purpose by the Joint Commission; or
b. be approved for its stated purpose by Medicare.

SURGERY.

a. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other procedures;
b. the correction of fractures and dislocations; or
c. pre-operative and post-operative care.

THERAPEUTIC MANIPULATION. Treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultrasound, doppler, whirlpool or hydrotherapy or other treatment of similar nature.

THERAPY SERVICES. The following services or supplies, ordered by a Provider and used to treat, or promote recovery from, an Injury or Illness:

Chelation Therapy—the administration of drugs or chemicals to remove toxic concentrations of metals from the body.

Chemotherapy—the treatment of malignant disease by chemical or biological antineoplastic agents.

Cognitive Rehabilitation Therapy—retraining the brain to perform intellectual skills which it was able to perform prior to disease, trauma, surgery, congenital anomaly or previous therapeutic process.

Dialysis Treatment—the treatment of an acute renal failure or chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.

Infusion Therapy—the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

Occupational Therapy—treatment to restore a physicially disabled person's ability to perform the ordinary tasks of daily living.

Physical Therapy—the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of a limb.

Radiation Therapy—the treatment of disease by X-ray, radium, cobalt, or high energy particle sources. Radiation Therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not Radiation Therapy.

Respiration Therapy—the introduction of dry or moist gases into the lungs.

Speech Therapy—treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes.

TOTAL DISABILITY OR TOTALLY DISABLED. Except as otherwise specified in this Contract, an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

***[WE, US, OUR.** [Carrier].

YOU, YOUR, AND YOURS. The Contract Holder.]*

IV. ELIGIBILITY

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the Contract, all of the Contract Holder's Employees [who are in an eligible class] will be eligible if the Employees are Actively at Work Full-Time Employees.

For purposes of this Contract, We will treat partners, proprietors and independent contractors like Employees if they meet the Contract's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement

[Carrier] will not cover an Employee unless the Employee is an Actively at work Full-Time Employee.

Enrollment Requirement

[[If an Employee must pay part of the cost of Employee Coverage,] We will not cover the Employee until the Employee enrolls and agrees to make the required payments***, if any***. If the Employee does this ***within [30] days of the Employee's Eligibility Date, coverage will start on the Employee's Eligibility Date.**

If the Employee enrolls and agrees to make the required payments, if any*:

a. more than *[*30*]* days after the *[Employee first becomes eligible]* ***Employee's Eligibility Date***; or
b. after the Employee previously had coverage which ended because the Employee failed to make a required payment,

We will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Contract's Pre-Existing Conditions limitation.

However,] if an Employee initially waived coverage under his Contract, and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Contract, We will not consider the Employee to be a Late Enrollee, provided the coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But the Employee must enroll under this Contract within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date he or she becomes eligible.

[The Waiting Period

This Contract has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least *[[3]]* *____* months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the Effective Date.

Employees in an Eligible Class on the Effective Date, who have not completed at least *[[3]]* *____* months of continuous Full-Time service with the Employer by that date, are eligible for coverage under this Contract from the day after Employees complete *[[3]]* *____* months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for coverage under this Contract from the day after Employees complete *[[3]]* *____* months of continuous Full-Time service with the Employer.]

Multiple Employment

If an Employee works for both the Contract Holder and a covered Affiliated Company, or for more than one covered Affiliated Company, We will treat the Employee as if only one firm employs the Employee. And such an Employee will not have multiple coverage under this Contract.

When Employee Coverage Starts

An Employee must be Actively at Work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, [Carrier] will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

*[The scheduled Effective Date of an Employee's coverage is a follows:

a. if an Employee must pay part of the cost of Employee coverage, then he or she]* ***The Employee*** must elect to enroll and agree to make the required payments ***if any,*** within *[*30*]* days of *[his or her]* ***the Employee's*** Eligibility Date. If he or she does this within *[*30*]* days of *[his or her]* ***the Employee's*** Eligibility Date, his or her coverage is scheduled to start on *[his or her]* ***the Employee's*** Eligibility Date. ***Such Employee's Eligibility Date is scheduled Effective Date of an Employee's coverage.***

[b. on non-contributory plans, subject to all the terms of this plan, an Employee's coverage is scheduled to start on his or her eligibility date.]]

When Employee Coverage Ends

An Employee's coverage under this Contract will end on the first of the following dates:

a. [the date] an Employee ceases to be an Actively at Work Full-Time Employee for any reason. Such reasons include disability, death, retirement, lay-off, leave of absence, and the end of employment.
b. [the date] an Employee stops being an eligible Employee under this Contract.
c. the date this Contract ends, [or is discontinued for a class of Employees to which the Employee belongs.]
d. [the date] for which required payments are not made for the Employee.
e. [the date] an Employee moves his or her permanent residence outside the Service Area.

Also, an Employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. This Contract's benefits provisions explain these situations. Read this Contract's provisions carefully.

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are:

a. the Employee's legal spouse;
b. the Employee's unmarried Dependent children who are under age 19; and
c. the Employee's unmarried Dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools. Full-time students will be defined by the accredited school. ***We can require periodic proof of a Dependent child's status as a full-time student.***

Adopted Children and Step-Children

An Employee's "unmarried Dependent children" include the Employee's legally adopted children, if they depend on the Employee for most of their support and maintenance, his or her step-children and children under a court appointed guardianship. [Carrier] will treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. [Carrier] will treat such a child this way whether or not a final adoption order is ever issued.

Eligible Dependents will not include any Dependent who is:

a. covered by this Contract as an Employee or
b. on active duty in the armed forces of any country.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the plan, such a child may stay eligible for Dependent health benefits past this Contract's age limit.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a. the child's condition started before he or she reached this Contract's age limit; ***and***
[b. the child became covered by this Contract before the child reached the age limit, and stayed continuously covered until reaching such limit; and]
*[c.]*** ***b.*** *the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Us written proof that the child is handicapped and depends on the Employee for most support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, We cannot ask for this more than once a year.

The child's coverage ends when the Employee's does.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Contract. [Carrier] considers an eligible Dependent to be a Late Enrollee, if the Employee:

a. enrolls a Dependent [and agrees to make the required payments] *[after the end of the enrollment period]* ***more than [30] days after the Dependent's Eligibility Date****;
b. in the case of a Newly Acquired Dependent, other than the first newborn child, has other eligible Dependents who the Employee has not elected to enroll; or
c. in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees are subject to this Contract's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

However, if the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Contract ***and stated at that time that such waiver was*** because they were

covered under another group plan, and the Employee now elects to enroll them in this Contract, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a. termination of employment;
b. divorce;
c. death of the Employee's spouse; or
d. termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. ***Coverage will take effect as of the date one of the above events occurs.***

And, [Carrier] will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Contract, to be a Late Enrollee, if:

a. the Employee is under legal obligation to provide coverage due to a court order; and
b. the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to the court order.

When Dependent Coverage Starts

In order for an Employee's dependent coverage to begin the Employee must already be covered for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to the **exception** stated below and to all of the terms of this Contract, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents [and agrees to make any required payments].

If the Employee does this *[on or before the Employee's]* ***within 30 days of the Dependent's*** Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:

a. the *[Employee's]* ***Dependent's*** eligibility date, or
b. the date the Employee becomes covered for Employee coverage.

If the Employee does this *[within or after the enrollment period]* ***more than [30] days after the Dependent's Eligibility Date, We will consider the Dependent a Late Enrollee***, the coverage is scheduled to start on the later of:

a. the date the Employee signs the enrollment form; or
b. the date the Employee becomes covered for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents, the Employee must notify Us of a Newly Acquired Dependent within the *[enrollment period]* ***[30] days after the Dependent's Eligibility Date***. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent will be covered from the later of:

a. the date the Employee notifies [Carrier] [and agrees to make any additional payments], or
b. the *[date]* ***Dependent's Eligibility Date for*** the Newly Acquired Dependent is first eligible.

Exception: If a Dependent, other than a newborn child, is confined to a Hospital or other health care facility; or is home confined on the date the Employee's Dependent health benefits would otherwise start, [Carrier] will postpone the Effective Date of such benefits until the later of: the day after the Dependent's discharge from such facility; until home confinement ends.

Newborn Children

We will cover an Employee's newborn child for 31 days from the date of birth. Coverage may be continued beyond such 31 day period as stated below:

a. If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days[, provided the premium required for Dependent child coverage continues to be paid.]
b. If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:
   - make written request to enroll the newborn child[; and
   - pay the premium required for Dependent child coverage within 31 days after the date of birth.]

If the request is not made[and the premium is not paid] within such 31 day period, the newborn child will be a Late Enrollee.

When Dependent Coverage Ends:

A Dependent's coverage under this Contract will end on the first of the following dates:

a. [the date] Employee coverage ends;
[b. the date the Employee stops being a member of a class of Employees eligible for such coverage;]
[c.] the date this Contract ends;
[d.] the date Dependent coverage is dropped from this Contract for all Employees eligible for such coverage;
[e. the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.]
[f.] *[the date]* ***At 12:01 a.m. on the date*** the Dependent stops being an eligible Dependent. *[This happens at 12:01 a.m. on the date:
   - the child attains the Contract's age limit;
   - the Dependent child marries;
   - a step-child is no longer dependent on the Employee for support and maintenance;
   - a spouse's marriage ends in legal divorce or annulment.]*

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And divorced spouses have the right to replace certain group benefits with converted policies.

TERMINATION FOR CAUSE

If any of the following conditions exist, We may give written notice to the Member that the person is no longer covered under this Contract:

(1) **Untenable Relationship:** After reasonable efforts, We and/or [Participating] Providers are unable to establish and maintain a satisfactory relationship with the Member or the Member fails to abide by our rules and regulations, or the Member acts in a manner which is verbally or physically abusive.
(2) **Misuse of Identification Card:** The Member permits any other person who is not authorized by Us to use an identification card We issue to the Member.
(3) **Furnishing Incorrect or Incomplete Information:** The Member furnishes incorrect or incomplete information in a statement made for the purpose of effecting coverage under this Contract. This condition is subject to the provisions of the section Incontestability of Coverage.
(4) **Nonpayment:** The Member fails to pay any Copayment [or Coinsurance] or to make any reimbursement to Us required under this Contract.
(5) **Misconduct:** The Member abuses the system, including but not limited to; theft, damage to [Our] [Participating Provider's] property, forgery of drug prescriptions, and consistent failure to keep scheduled appointments.
(6) **Failure to Cooperate:** The Member fails to assist Us in coordinating benefits as described in the Coordination of Benefits Section.

If We give the Member such written notice:

(a) that person will cease to be a Member for the coverage under this Contract immediately if termination is occurring due to **Misuse of Identification Card** (2 above) or **Misconduct** (5 above), otherwise, on the date 31 days after such written notice is given by Us; and
(b) no benefits will be provided to the Member under the coverage after that date.

Any action by Us under these provisions is subject to review in accordance with the Grievance Procedures We establish.

V. COVERED SERVICES AND SUPPLIES

Members are entitled to receive the benefits in the following sections when Medically Necessary and Appropriate, subject to the payment by Members of applicable copayments [or co-insurance] as stated in the applicable Schedule of Services.

a. ***[Outpatient Benefits]* *OUTPATIENT SERVICES***. The following services are covered only at the Primary Care Physician's office [or Health Center] selected by a Member, or elsewhere upon prior written Referral by a Member's Primary Care Physician:
   1. **Office visits** during office hours, and during non-office hours when Medically Necessary.
   2. **Home visits** by a Member's Primary Care Physician.

3. **Periodic health examinations** to include:
   a. Well child care from birth including immunizations;
   b. Routine physical examinations, including eye examinations;
   c. Routine gynecologic exams and related services;
   d. Routine ear and hearing examination; and
   e. Routine allergy injections and immunizations (but not if solely for the purpose of travel or as a requirement of a Member's employment).
4. **Diagnostic Services.**
5. **Casts and dressings.**
6. **Ambulance Service** when certified in writing as Medically Necessary by a Member's Primary Care Physician and approved in advance by Us.
7. **Infertility Services** except where specifically excluded in this Contract.
8. **Prosthetic Devices** when We arrange for them. We cover only the initial fitting and purchase of artificial limbs and eyes, and other prosthetic devices. And they must take the place of a natural part of a Member's body, or be needed due to a functional birth defect in a covered Dependent Child. We do not provide for replacements (unless Medically Necessary and Appropriate), repairs, wigs, or dental prosthetics or devices.
9. **Durable Medical Equipment** when ordered by a Member's Primary Care Physician and arranged through Us.
10. **Prescription Drugs *and insulin syringes and insulin needles*** when obtained through a Participating Provider.

b. **SPECIALIST DOCTOR BENEFITS.** The following Services are covered when rendered by a Participating Specialist Doctor at the doctor's office[, or Health Center,] or any other Participating Facility or a Participating Hospital outpatient department during office or business hours upon prior written referral by a Member's Primary Care Physician. Services include but are not limited to the following:
   1. Allergy (except serum injections which are covered when administered by a Member's Primary Care Physician)
   2. Anesthesia
   3. Cardiology
   4. Endocrinology
   [5. Gynecology and Obstetrics]
   6. Internal Medicine
   7. Neurology
   8. Oncology
   9. Ophthalmology
   10. Oral Surgery (bone fractures, removal of tumors and orthodontogenic cysts or other approved surgical procedures by Us)
   11. Orthopedics
   12. Otolaryngology
   13. Pathology
   14. Pediatrics
   15. Podiatry
   16. Pulmonology
   17. Radiology (except dental x-rays, unless related to Covered Services)
   18. Surgery
   19. Urology

c. **INPATIENT *HOSPICE,* HOSPITAL *,REHABILITATION CENTER* AND SKILLED NURSING CENTER BENEFITS.** The following Services are covered when hospitalized by a Participating Provider upon prior written referral from a Member's Primary Care Physician, only at Participating Hospitals and Participating Providers (or at Non-participating facilities upon prior written authorization by Us); however, Participating Skilled Nursing Center *[benefits]* ***Services and Supplies*** are limited to those which constitute Skilled Nursing Care ***and Hospice Services are subject to Our pre-approval***:
   1. Semi-private room and board accommodations
   2. Private accommodations [will be provided only when approved in advance by Us]. If a Member occupies a private room without such certification Member shall be directly liable to the ***Hospice,*** Hospital***, Rehabilitation Center*** or Skilled Nursing Center for the difference between payment by Us to the ***Hospice,*** Hospital***, Rehabilitation Center*** or Skilled Nursing Center of the per diem or other agreed upon rate for semi-private accommodation established between Us and the ***Participating Hospice,*** Participating Hospital***, Participating Rehabilitation Center*** or the Participating Skilled Nursing Center and the private room rate.
   3. General nursing care
   4. Use of intensive or special care facilities
   5. X-ray examinations including CAT scans but not dental x-rays
   6. Use of operating room and related facilities
   7. Magnetic resonance imaging ***"MRI"***
   8. Drugs, medications, biologicals
   9. Cardiography/Encephalography
   10. Laboratory testing and services
   11. Pre- and post-operative care
   12. Special tests
   13. Nuclear medicine
   14. Therapy Services
   15. Oxygen and oxygen therapy
   16. Anesthesia and anesthesia services
   17. Blood, blood products and blood processing
   18. Intravenous injections and solutions
   19. Surgical, medical and obstetrical services
   20. Private duty nursing only when approved in advance by Us.
   21. The following transplants: Cornea, Kidney, Lung, Liver, Heart and Pancreas
   22. Allogeneic bone marrow transplants
   23. *[The autologous]* ***Autologous*** bone marrow transplants and associated high dose chemotherapy: only for treatment of Leukemia, Lymphoma, Neuroblastoma, Aplastic Anemia, Genetic Disorders (SCID and WISCOT Alldrich).

d. **BENEFITS FOR SUBSTANCE ABUSE AND MENTAL AND NERVOUS CONDITIONS.** The following Services are covered when rendered by a Participating Provider at Provider's office or at a Participating Substance Abuse Center [or Health Center] upon prior written referral by a Member's Primary Care Physician.
   1. **Outpatient.** Members are entitled to receive up to twenty (20) outpatient visits during any period of 365 consecutive days. Benefits include diagnosis, medical, psychiatric and psychological treatment and medical referral services by a Member's Primary Care Physician for the abuse of or addiction to drugs and Mental or Nervous Conditions. Payment for non-medical ancillary services (such as vocational rehabilitation or employment counseling) is not provided, but information regarding appropriate agencies will be provided if available. Members are additionally eligible, upon referral by a Member's Primary Care Physician, for up to sixty (60) more outpatient visits by exchanging on a two-for-one basis, each inpatient hospital day described in paragraph 2 below.
   2. **Inpatient Hospital Care.** Members are entitled to receive up to thirty (30) days of inpatient care benefits for detoxification, medical treatment for medical conditions resulting from the substance abuse, referral services for substance abuse or addiction, and Mental or Nervous Conditions. The following services shall be covered under inpatient treatment: (1) lodging and dietary services; (2) physician, psychologist, nurse, certified addictions counselor and trained staff services; (3) diagnostic x-ray; (4) psychiatric, psychological and medical laboratory testing; (5) drugs, medicines, equipment use and supplies.

      Chemical Dependency Admissions. Repeated detoxification treatment for chronic Substance Abuse will not be covered unless in Our sole discretion it is determined that Members have been cooperative with an on-going treatment plan developed by a Participating Provider. Failure to comply with treatment shall constitute cause for non-coverage of Substance Abuse services.
   3. Court-ordered chemical dependency admissions are not covered unless Medically Necessary and Appropriate and only to the extent of the covered benefit as defined above.

e. **EMERGENCY CARE BENEFITS—WITHIN AND OUTSIDE OUR SERVICE AREA.** The following Services are covered without prior written referral by a Member's Primary Care Physician in the event of a Medical Emergency as determined by Us.

1. A Member's Primary Care Physician is required to provide or arrange for on-call coverage twenty-four (24) hours a day, seven (7) days a week. Unless a delay would be detrimental to a Member's health, Member shall call a Member's Primary Care Physician [or Health Center] [or Us] prior to seeking emergency treatment.
2. We will cover the cost of emergency medical and hospital services performed within or outside our service area without a prior written referral only if:
   a. Our review determines that a Member's symptoms were severe and delay of treatment would have been detrimental to a Member's health, the symptoms occurred suddenly, and Member sought immediate medical attention. Conditions which require immediate treatment include, but are not limited to the following:
      1. heart attacks
      2. strokes
      3. convulsions
      4. serious burns
      5. obvious bone fractures
      6. wounds requiring sutures
      7. poisoning
      8. loss of consciousness

      A near-term delivery is not a Medical Emergency.
   b. The service rendered is provided as a *[benefit]* ***Covered Service or Supply*** under this Contract and is not a service ***or supply*** which is normally treated on a non-emergency basis; and
   c. We and a Member's Primary care Physician are notified within 48 hours of the emergency service and/or admission and We are furnished with written proof of the occurrence, nature and extent of the emergency services within 30 days. Member shall be responsible for payment for services received unless We determine that a Member's failure to do so was reasonable under the circumstances. In no event shall reimbursement be made until We receive proper written proof.
3. In the event Members are hospitalized in a Non-participating facility, coverage will only be provided until Members are medically able to travel or to be transported to a Participating facility. If Members elect to continue treatment with Non-participating Providers, We shall have no responsibility for payment beyond the date Members are determined to be medically able to be transported.

   In the event that transportation is Medically Necessary and Appropriate, We will cover the Reasonable and Customary cost. Reimbursement may be subject to payment by Members of all Copayments which would have been required had similar benefits been provided *[during office hours and]* upon prior written referral to ***a*** Participating Provider.
4. Coverage for emergency services includes only such treatment necessary to treat the Medical Emergency. Any elective procedures performed after Members have been admitted to a facility as the result of a Medical Emergency shall require prior written referral or Member shall be responsible for payment.
5. The Copayment for an emergency room visit will *[not apply in the event that]* ***be credited toward the Hospital Inpatient Copayment if*** Members are admitted as an Inpatient to the Hospital as a result of the Medical Emergency.

f. **THERAPY SERVICES.** The following Services are covered when rendered by a Participating Provider upon prior written referral by a Member's Primary Care Physician.
   1. Speech Therapy, Physical Therapy, Occupational Therapy and Cognitive Therapies are covered for non-chronic conditions and acute Illnesses and Injuries upon referral to a Participating Provider by a Member's Primary Care Physician. This benefit consists of treatment for a 60 day period per incident of Illness or Injury, beginning with the first day of treatment, provided that a Member's Primary Care Physician certifies in writing that the treatment will result in a significant improvement of a Member's condition within this time period and treatment is approved in writing by Us.
   2. Chelation Therapy, Chemotherapy treatment, Dialysis Treatment, Infusion Therapy and Radiation Therapy.

g. **HOME HEALTH *[BENEFITS]* *SERVICES*.** The following Services are covered when rendered by a Participating ***Provider including but not limited to a Participating*** Home Health Agency as an alternative to hospitalization and are approved and coordinated in advance by Us upon the prior referral of a Member's Primary Care Physician.
   1. Skilled nursing services, provided by or under the supervision of a registered professional nurse.
   2. Services of a home health aide, under the supervision of a registered professional nurse, or if appropriate, a qualified speech or physical therapist. These benefits are covered only when the primary purpose of the Home Health Services rendered to Member is skilled in nature.
   3. Medical Social Services by or under the supervision of a qualified medical or psychiatric social worker, in conjunction with other Home Health Services, if the Primary Care Physician certifies that such services are essential for the effective treatment of a Member's medical condition.
   4. Therapy Services as set forth above.
   5. Hospice Care if Members are terminally ill with life expectancy of six months or less, as certified by the Member's Primary Care Physician. Services may include home and hospital visits by nurses and social workers; pain management and symptom control; instruction and supervision of family members; inpatient care; counseling and emotional support; and other Home Health benefits listed above.

   Nothing in this section shall require Us to provide Home Health Benefits when in our determination the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide Medically Necessary and Appropriate Care.

VI. NON-COVERED SERVICES AND SUPPLIES

THE FOLLOWING ARE NOT COVERED SERVICES UNDER THIS CONTRACT.

Care or treatment by means of **acupuncture** except when used as a substitute for other forms of anesthesia.

Services for **ambulance** for transportation from a Hospital or other health care Facility, unless Member is being transferred to another Inpatient health care Facility.

[Broken Appointments.]

Blood or blood plasma which is replaced by or for a Member.

Care and/or treatment by a **Christian Science Practitioner.**

Completion of claim forms.

Services or supplies related to **cosmetic surgery,** except as otherwise stated in this Contract, unless it is required as a result of an ***Illness or*** Injury sustained while covered under this Contract or to correct a functional defect resulting from a congenital abnormality or developmental anomaly; complications of cosmetic surgery; drugs prescribed for cosmetic purposes.

Services related to **custodial** or **domiciliary** care.

Dental care or treatment, including appliances, except as otherwise stated in this Contract.

Services or supplies, the primary purpose of which is **educational** providing the Member with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a. exams to determine the need for (or changes of) **eyeglasses** or lenses of any type;
b. eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c. eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmation (blurring).

Services or supplies provided by one of the following members of the Employee's **family**: spouse, child, parent, in-law, brother, sister or grandparent.

Care and/or treatment to enhance **fertility** using artificial and surgical procedures and drugs, including, but not limited to, invitro fertilization, invivo fertilization or gamete-intrafalopian-transfer (GIFT); surrogate motherhood.

Services or supplies related to **Hearing aids*[,]* *and* hearing examinations *to determine the need for hearing aids or the need to adjust them*** *[or fitting of hearing aids]*.

Services or supplies related to **Herbal medicine.**

Care or treatment by means of **high dose chemotherapy,** except as otherwise stated in the Contract.

Services or supplies related to **Hypnotism.**

Services or supplies because the Covered Person engaged, or tried to engage, in an **illegal occupation** or committed or tried to commit a felony.

Illness or Injury, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law;

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related to **Marriage, career or financial counseling, sex therapy or family therapy, and related services.**

Supplies related to **Methadone** maintenance.

Any **Non-Covered Service or Supply** specifically limited or not covered elsewhere in this Contract, or which is **not Medically Necessary and Appropriate.**

Non-prescription drugs or supplies, except insulin needles and insulin syringes.

Services provided by a licensed **pastoral counselor** in the course of his or her normal duties as a religious ***official or practitioner***.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

[Pre-Existing Condition Limitations: We do not cover services for Pre-Existing Conditions until Members have been covered by this Contract for six months. See the "Definitions" section of this Contract for the definition of a Pre-Existing Condition. This limitation does not affect services or supplies for other unrelated conditions, or birth defects in a covered Dependent Child. And We waive this limitation for A Member's Pre-Existing Condition to the extent that if the condition was satisfied under another carrier's plan which covered Member right before the Member's coverage under this Contract started, i.e., there is no intervening lapse in coverage.]

Any service provided without prior written Referral by the Member's **Primary Care Physician** except as specified in this Contract.

In the event of a Medical Emergency, the amount of any charge which is greater than a **Reasonable and Customary Charge.**

Services or supplies related to **rest or convalescent cures.**

Room and board charges for a Member in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Services or supplies related to **Routine Foot Care.**

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services or supplies:

a. eligible for payment under either federal or state programs (except Medicaid). This provision applies whether or not the Member asserts his or her rights to obtain this coverage or payment for these services;
b. for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c. for which a Member would not have been charged if he or she did not have health care coverage;
d. provided by or in a Government Hospital unless the services are for treatment:
   - of a non-service Medical Emergency; or
   - by a Veterans' Administration Hospital of a non-service related Illness or Injury.

Smoking cessation aids of all kinds and the services of stop-smoking providers.

Sterilization reversal—services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Member's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in the Contract.

Transportation; travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a **war,** declared or undeclared; police actions; services in the armed forces or units auxiliary thereto; or riots or insurrection.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products.

Wigs, toupees, hair transplants, hair weaving or any drug *if such drug is* used in connection with baldness.

VII. GRIEVANCE PROCEDURE

[Grievance Procedure: Variable by Carrier as approved by the State of New Jersey.]

VIII. COORDINATION OF BENEFITS *AND SERVICES*

COORDINATION OF BENEFITS

Purpose Of This Provision

A Member may be covered for health benefits by more than one plan. For instance, he or she may be covered by this Contract as an Employee and by another plan as a Dependent of his or her spouse. If he or she is, this provision allows Us to coordinate what We arrange [or provide] with what another plan pays. We do this so the Member does not collect more in benefits that he or she incurs in charges.

DEFINITIONS

"Plan" means any of the following that provide health expense benefits or services:

a. group or blanket insurance plans;
b. group hospital or surgical plans, or other service or prepayment plans on a group basis;
c. union welfare plans, Employer plan, Employee benefits plans, trusteed labor and management plans, or other plans for members of a group;
d. programs or coverages required by law;
e. group or group-type hospital indemnity benefits which exceed *[$150.00]* *_____* per day*[.]*

"Plan" does not include:

a. Medicaid or any other government program or coverage which [Carrier] is not allowed to coordinate with by law;
b. school accident type coverages written on either a blanket, group, or franchise basis;
c. group or group-type hospital indemnity benefits of *[$150.00]* *_____* per day or less; *[and]*
d. any plan We say We supplement.

"This plan" means the part of Our group plan subject to this provision.

"*[Member]* *_____*", as used below, means the person who receives a certificate or other proof of coverage from a plan that covers him or her for health benefits.

"Dependent" means a person who is covered by a plan for health benefits, but not as a *[member]* *_____*.

"Allowable expense" means any necessary, reasonable, and usual item of expense for health care incurred by a *[member]* *_____* or Dependent under either this plan or any other plan. When a plan provides service instead of cash payment, We view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view items of expense covered by another plan as an allowable expense, whether or not a claim is filed under that plan.

The amount of reduction in benefits resulting from a *[member]* *_____*'s or Dependent's failure to comply with provisions of a primary plan is not considered an allowable expense if such reduction in benefit is less than or equal to the reduction that would have been made under the terms if this Plan had been primary. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services, and preferred provider arrangements. This does not apply where a primary plan is a health maintenance organization (HMO) and the *[member]* *_____* or Dependent elects to have health services provide outside the HMO. A primary plan is described below.

"Claim determination period" means a Calendar Year in which a *[member]* *_____* or Dependent is covered by this plan and at least one other plan and incurs one or more allowable expense(s) under such plans.

How This Provision Works

We apply this provision when a *[member]* *_____* or Dependent is covered by more than one plan. When this happens We will consider each plan separately when coordinating payments.

In order to apply this provision, one of the plans is called the primary plan. All other plans are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans *[than]* ***then*** pay the remaining unpaid allowable expenses, but no plan pays more than it would have without this provision.

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

a. A plan that covers a person as a *[member]* *_____* pays first; the plan that covers a person as a Dependent pays second.

b. A plan that covers a person as an active Employee or as a Dependent of such Employee pays first. A plan that covers a person as a laid-off or retired Employee or as a Dependent of such Employee pays second.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then b. will not apply.

c. Except for Dependent children of separated or divorce parents, the following governs which plan pay first when the person is a Dependent of a *[member]* *_____*:

A plan that covers a Dependent of a member whose birthday falls earliest in the Calendar Year pays first. The plan that covers a Dependent of a *[member]* *_____* whose birthday falls later in the Calendar Year pays second. The *[member]* *_____*'s year of birth is ignored.

But, if the plan that We are coordinating with does not have a similar provision for such persons, then c. will not apply and the other plan's coordination provision will determine the order of benefits.

d. For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a *[member]* *_____*.

- When a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first.
- If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
- The plan of the stepparent with custody pays before the plan of the natural parent without custody.

If rules a, b, c and d do not determine which plan pays first, the plan that has covered the person for the longer time pays first.

If, when We apply this provision, We pay less than We would otherwise pay, We apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits, We need certain information. An Employee must supply Us with as much of that information as he or she can. But if he or she cannot give Us all the information We need, We have the right to get this information from any source. And if another *[insurer]* ***carrier*** needs information to apply its coordination provision, We have the right to give that *[insurer]* ***carrier*** such information. If We give or get information under this section We cannot be held liable for such action.

When payments that should have been made by this plan have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. And if We pay out more than We should have, We have the right to recover the excess payment.

Small Claims Waiver

We do not coordinate claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00 We will count the entire amount of the claim when We coordinate.]

[BENEFITS]* *_____* FOR AUTOMOBILE RELATED INJURIES

This section will be used to determine a person's *[benefits]* *_____* under this Contract when services are incurred as a result of an automobile related Injury.

Definitions

"Automobile Related Injury" means bodily Injury sustained by a Member as a result of an accident:

a. while occupying, entering, leaving or using an automobile; or

b. as a pedestrian;

caused by an automobile or by an object propelled by or from an automobile.

"Allowable Expense" means a medically necessary, reasonable and customary item of expense covered at least in part as an eligible expense by:

a. this Contract;

b. PIP; or

c. OSAIC.

"Eligible *[Expense]* *_____*" means that *[portion of expense incurred]* *_____* for treatment of an Injury which is covered under this Contract without application of Cash Deductibles and Co-Payments, if any or Co-Insurance.

"Out-of-State Automobile Insurance Coverage" or "OSAIC" means any coverage for medical expenses under an automobile insurance policy other than PIP. OSAIC includes automobile insurance policies issued in another state or jurisdiction.

"PIP" means personal injury protection coverage provided as part of an automobile insurance policy issued in New Jersey. PIP refers specifically to provisions for medical expense coverage.

Determination of primary or secondary coverage.

This Contract provides secondary coverage to PIP unless health coverage has been elected as primary coverage by or for the Member under this Contract. This election is made by the named insured under a PIP policy. Such election affects that person's family members who are not themselves named insureds under another automobile policy. This Contract may be primary for one Member, but not for another if the person has ***a*** separate automobile *[policies]* ***policy*** and *[have]* ***has*** made different selection*[s]* regarding primacy of health coverage.

This Contract is secondary to OSAIC, unless the OSAIC contains provisions which make it secondary or excess to the policyholder's plan. In that case this Contract will be primary.

If there is a dispute as to which policy is primary, this Contract will pay benefits as if it were primary.

Benefits *Services _____* this Contract will *[pay]* *_____* if it is primary to PIP or OSAIC.

If this Contract is primary to PIP or OSAIC it will *[pay]* *_____* benefits for eligible expenses in accordance with its terms.

The rules of the **COORDINATION OF BENEFITS** section of this Contract will apply if:

- the Member is insured under more than one insurance plan; and
- such insurance plans are primary to automobile insurance coverage.

Benefits this Contract will pay if it is secondary to PIP or OSAIC.

If this Contract is secondary to PIP or OSAIC the actual benefits payable will be the lesser of:

a. the allowable expenses left uncovered after PIP or OSAIC has provided coverage after applying Cash Deductibles and Co-Payment, or

b. the *[benefits that would have been paid]* *_____* if this Contract has been primary.

IX. CONTRACT HOLDER GENERAL PROVISIONS

AMENDMENTS

The Contract may be amended, at any time, without a Member's consent or ***that*** of anyone else with a beneficial interest in it. The Contract Holder may change the type of coverage under this Contract at any time by notifying Us in writing.

We may make amendments to the Contract upon 30 days' notice to the Contract Holder, and as provided in (b) and (c) below. An amendment will not affect benefits for a service or supply furnished before the date of change; and no change to the benefits under this Contract will be made without the approval of the Board.

Only Our officers have authority: to waive any conditions or restrictions of the Contract, to extend the time in which a Premium may be paid, to make or change a Contract, or to bind Us by a promise or representation or by information given or received.

No change in the Contract is valid unless the change is shown in one of the following ways:

a. it is shown in an endorsement on it signed by one of Our officers.
b. if a change has been automatically made to satisfy the requirements of any state or federal law that applies to the Contract, as provided in the section of this Contract called "Conformity With Law," it is shown in an amendment to it that is signed by one of Our officers.
c. if a change is required by Us, it is accepted by the Contract Holder, as evidenced by payment of a Premium on or after the effective date of such change.
d. if a written request for a change is made by the Contract Holder, it is shown in an amendment to it signed by the Contract Holder and by one of Our Officers.

ASSIGNMENT

No assignment or transfer by the Contract Holder of any of the Contract Holder's interest under this Contract is valid unless We consent thereto.

CLERICAL ERROR—MISSTATEMENTS

No clerical error by Us in keeping any records pertaining to Coverage under this Contract will reduce a Member's Coverage. Neither will delays in making those records reduce it. However, if We discover such an error or delay, a fair adjustment of Premiums will be made.

CONFORMITY WITH LAW

Any provision of this Contract which, on its Effective Date, is in conflict with the statutes of the *[state in which the Member resides]* ***State of New Jersey***, or with Federal law, is hereby amended to conform to the minimum requirements of such State law or Federal law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONTRACT INTERPRETATION

We shall administer Contract in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

[CONVERSION PRIVILEGE

If an Employee's Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.]

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with Fraudulent statements.

If this Contract replaces the contract of another insurer, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to the Contract Holder: To the last address provided by the Contract Holder on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Contract Holder's application may not be used by Us to void this Contract or in any legal action unless the application or a duplication of it is attached to this Contract or has been furnished to the Contract Holder for attachment to this Contract.

PREMIUM AMOUNTS

The Premium due on each Premium Due Date is the sum of the Premium charges for the coverage You have. Those charges are Determined from the Premium rates then in effect and the Employees then covered.

Premium payments may be determined in another way. But it must produce about the same amounts and be agreed to by the Contract Holder and Us.

The following will apply if one or more Premiums paid include Premium charges for a Member whose coverage has ended before the due date of that Premium. We will not have to refund more than the amount of (a) minus (b):

a. the amounts of the Premium charges for the Member that were included in the Premiums paid for the two-month period immediately before the date We receive written notice from the Contract Holder that the Member's coverage has ended.
b. the amount of any claims paid or the value of any services provided to You or to a member of Your family after that person's coverage has ended.

PAYMENT OF PREMIUMS—GRACE PERIOD

Premiums are to be paid by the Contract Holder to Us. They are due on each Premium Due Date stated on the first page of the Contract. The Contract Holder may pay each Premium other than the first within 31 days of the Premium Due Date. Those days are known as the grace period. The Contract Holder is liable to pay Premiums to Us from the first day the Contract is in force. Premiums accepted by Us after the end of the grace period are subject to a late payment interest charge determined as a percentage of the amount unpaid. That percentage will be Determined by Us from time to time, but will not be more than the maximum allowed by law.

PREMIUM RATE CHANGES

The Premium rates in effect on the Effective Date are shown in the Premium Rates and Provisions section of the Contract. We have the right to change Premium rates as of any of these dates:

a. any Premium Due Date;
b. any date that an Employer becomes, or ceases to be, an Affiliated Company.
c. any date that the extent or nature of the risk under the Contract is changed:
    1. by amendment of the Contract; or
    2. by reason of any provision of law or any government program or regulation;
d. at the discovery of a clerical error or misstatement as described below.
e. As of the date the nature of the Contract Holder's business changes.

We will give You 30 days written notice when a change in the Premium rates is made.

TERMINATION OF THE CONTRACT—RENEWAL PRIVILEGE

We have the right to cancel this Contract on any premium due date subject to 30 days advance written notice to the Contract Holder for the following reasons:

a. During or End of Grace Period—Failure to Pay Premiums: If any premium is not paid by the end of its grace period, this *[Policy]* ***Contract*** will automatically end when that period ends. But the Contract Holder may write to Us, in advance, to ask that this Contract be ended at the end of the period for which premiums have been paid or at any time during the grace period. Then this Contract will end on the date requested.
b. the *[Policyholder]* ***Contract Holder*** moves its principal place of business outside the State of New Jersey;
c. subject to the statutory notification requirements, We cease to do business in the small group market;

d. with respect to Contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.); or

e. with respect to Non-contributory Contracts, less than [75%] of the Employer's eligible Employees are covered by this Contract. (If an eligible Employee is not covered by this Contract because:
   1. the Employee is covered as a Dependent under a spouse's coverage; or
   2. the Employee is covered under an alternate health benefits plan offered by the Contract Holder, We will count that Employee as being covered by this Contract for purposes of satisfying participation requirements.)

Immediate cancellation will occur if the Contract Holder commits fraudulent acts or makes misrepresentations with respect to coverage of eligible Employees or Dependents or status as a Small Employer.

This Contract is issued for a term of one (1) year from the Effective Date shown on the first page of this Contract. All Contract Years and Contract Months will be calculated from the Effective Date. All periods of coverage hereunder will begin and end at 12:00:01 a.m. Eastern Standard Time at the Contract Holder's place of business.

The Contract Holder may renew this Contract for a further term of one (1) year, on the first and each subsequent Contract Anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this Contract's Premium Amounts section.

However, We have the right to non-renew this Contract on any Contract Anniversary if the Contract Holder is no longer a Small Employer.

The Employer must certify to Us the Employer's status as a Small Employer every year. Certification must be given to Us within 10 days of the date We request it. If Employer fails to do this, We retain the right to take the actions described above as of the Employer's Contract Anniversary.

[Also, if the nature of the Employer's business changes, the Employer must notify Us within 30 days. We have the right to change the rates We charge for this Contract if this happens. If the Employer fails to notify Us within 30 days, We have the right to adjust premium rates retroactively to the date the nature of the Employer's business changed.] **[Note: This section will sunset January 1, 1997]**

THE CONTRACT

The entire Contract consists of:

[a. the forms shown in the Table of Contents as of the Effective Date;
b.] the Contract Holder's application, a copy of which is attached to the Contract;
[c.] any riders, [endorsements] or amendments to the Contract; and
[d.] the individual applications, if any, of all Members.

X. MEMBER GENERAL PROVISIONS

ASSIGNMENT

No assignment or transfer by a Member of any of his or her interest under this Contract is valid unless We consent thereto.

CONFIDENTIALITY

Information contained in the medical records of Members and information received from physicians, surgeons, hospitals or other health professionals incident to the physician-patient relationship or hospital-patient relationship shall be kept confidential by Us; and except for use incident to bona fide medical research and education as may be permitted by law, or reasonably necessary in connection with the administration of this Contract or in the compiling of aggregate statistical data, or with respect to arbitration proceedings or litigation initiated by Member against Us may not be disclosed without the Member's written consent, except as required by law.

CONTINUING RIGHTS

Our failure to apply terms or conditions does not mean that We waive or give up any future rights under this Contract.

CONVERSION PRIVILEGE

If a *[Member's]* ***Subscriber's*** Spouse loses coverage due to a divorce, the Spouse may apply for an individual health benefits plan. An application must be made within 31 days of the occurrence of the divorce.

GOVERNING LAW

This entire Contract is governed by the laws of the State of New Jersey.

IDENTIFICATION CARD

The Identification Card issued by Us to Members pursuant to this Contract is for identification purposes only. Possession of an Identification Card confers no right to services or benefits under this Contract, and misuse of such identification card constitutes grounds for termination of Member's coverage. If the Member who misuses the card is the Employee, coverage may be terminated for the Employee as well as any of the Employee's Dependents who are Members. To be eligible for services or benefits under this Contract, the holder of the card must be a Member on whose behalf all applicable premium charges under this Contract have been paid. Any person receiving services or benefits which he or she is not entitled to receive pursuant to the provisions of this Contract shall be charged for such services or benefits at prevailing rates.

If any Member permits the use of his or her Identification Card by any other person, such card may be retained by Us, and all rights of such Member and his or her Dependents, if any, pursuant to this Contract shall be terminated immediately, subject to the Grievance Procedures.

INABILITY TO PROVIDE SERVICE

In the event that due to circumstances not within our reasonable control, including but not limited to major disaster, epidemic, complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of our Participating Providers or entities with whom We have arranged for services under this Contract, or similar causes, the rendition of medical or hospital benefits or other services provided under this Contract is delayed or rendered impractical, We shall not have any liability or obligation on account of such delay or failure to provide services, except to refund the amount of the unearned prepaid premiums held by Us on the date such event occurs. We are required only to make a good faith effort to provide or arrange for the provision of services, taking into account the impact of the event.

INCONTESTABILITY OF THE CONTRACT

There will be no contest of the validity of the Contract, except for not paying premiums, after it has been in force for two years.

No statement in any application, except a fraudulent statement, made by the Contract Holder or by a Member covered under this Contract shall be used in contesting the validity of his or her coverage or in denying benefits after such coverage has been in force for two years during the person's lifetime. Note: There is no time limit with respect to a contest in connection with fraudulent statements.

If this Contract replaces the contract of another insurer, we may rescind this Contract based on misrepresentations made in the Contract Holder's or a Member's signed application for up to two years from this Contract's Effective Date.

INDEPENDENT CONTRACTOR RELATIONSHIP

1. No Participating Provider or other provider, institution, facility or agency is our agent or employee. Neither We nor Our employees are an agent or employee of any Participating Provider or other provider, institution, facility or agency.
2. Neither the Contract Holder nor any Member is our agent, representative or employee, or an agent or representative of any Participating Provider or other person or organization with which We have made or hereafter shall make arrangements for services under this Contract.
3. Participating Physicians maintain the physician-patient relationship with Members and are solely responsible to Member for all medical services which are rendered by Participating Physicians.
4. No Contract Holder or Member shall make or assert a claim inconsistent with the foregoing unless based upon a writing signed by one of Our officers.

LIMITATION OF ACTIONS

No action at law or in equity shall be brought to recover on the Contract until 60 days after a Member files written proof of loss. No such action shall be brought more than three years after the end of the time within which proof of loss is required.

LIMITATION ON SERVICES

Except in cases of Medical Emergency, services are available only from Participating Providers. We shall have no liability or obligation whatsoever on account of any service or benefit sought or received by a Member from any Physician, Hospital, other Provider or other person, entity, institution or organization unless prior arrangements are made by Us.

MEDICAL NECESSITY

Members will receive designated benefits under the Contract only when Medically Necessary and Appropriate. We may determine whether any benefit provided under the Contract was Medically Necessary and Appropriate, and We have the option to select the appropriate Participating Hospital to render services if hospitalization is necessary. Decisions as to medical necessity are subject to review by [our quality assessment committee or its physician designee]. We will not, however, seek reimbursement from an eligible Member for the cost of any covered benefit provided under the Contract that is later determined to have been medically unnecessary and inappropriate, when such service is rendered by a Primary Care Physician or a provider referred in writing by the Primary Care Physician without notifying the Member that such benefit would not be covered under this Contract.

NOTICES AND OTHER INFORMATION

Any notices, documents, or other information under the Contract may be sent by United States Mail, postage prepaid, addressed as follows:

If to Us: To Our last address on record.

If to a Member: to the last address provided by the Member on an enrollment or change of address form actually delivered to Us.

OTHER RIGHTS

We are only required to provide benefits to the extent stated in this Contract, its riders and attachments. We have no other liability.

Services and supplies are to be provided in the most cost-effective manner practicable as Determined by Us.

We reserve the right to use Our subsidiaries or appropriate employees or companies in administering this Contract.

We reserve the right to modify or replace an erroneously issued Contract.

Information in a Member's application may not be used by Us to void this Contract or in any legal action unless the application or a duplicate of it is attached to this Contract or has been *[furnished]* **mailed** to a Member for attachment to this Contract.

CONTRACT INTERPRETATION

We shall administer Contracts in accordance with its terms and shall have the sole power to determine all questions arising in connection with its administration, interpretation and application.

REFERRAL FORMS

A Member can be referred for Specialist Services by a Member's Primary Care Physician.

Member will be responsible for the cost of all services provided by anyone other than a Member's Primary Care Physician (including but not limited to Specialist Services) if a Member has not been referred by his or her Primary Care Physician.

REFUSAL OF TREATMENT/NON-COMPLIANCE WITH TREATMENT RECOMMENDATION

A Member may, for personal reasons disagree or not comply with procedures, medicines, or courses of treatment recommended by a Participating Physician or ignore treatment that is deemed Medically Necessary by a Participating Physician. If such Participating Physician (after a second Participating Physician's opinion, if requested by Member), believes that no professionally acceptable alternative exists, and if after being so advised, Member still refuses to comply with or accept the recommended treatment or procedure, neither the Physician, nor We, or any Participating Provider will have further responsibility to provide any of the benefits available under this Contract for treatment of such condition or its consequences or related conditions. We will provide written notice to Member of a decision not to provide further benefits for a particular condition. The decision is subject to the Grievance Procedures. Treatment for the condition involved will be resumed in the event Member agrees to follow the recommended treatment or procedure.

REPORTS AND RECORDS

We are entitled to receive from any provider of services to Member such information We deem is necessary to administer this Contract subject to all applicable confidentiality requirements as defined in this Contract. By accepting coverage under this Contract, *[Contract Holder]* **Subscriber**, for himself or herself, and for all Dependents covered hereunder, authorizes each and every provider who renders services to **the** Member hereunder to disclose to Us all facts and information pertaining to the care, treatment and physical condition of Member and render reports pertaining to same to Us upon request and to permit copying of **a** Member's records by us.

SELECTING OR CHANGING A PRIMARY CARE PHYSICIAN [OR HEALTH CENTER]

When an Employee first obtains this coverage, the Employee and each of the Employee's covered Dependents must select a Primary Care Physician [or Health Center].

Members select a Primary Care Physician from Our [**Physician or** Practitioners Directory]; this choice is solely a Member's. However, We cannot guarantee the availability of a particular doctor. If the Primary Care Physician initially selected cannot accept additional patients, a Member will be notified and given an opportunity to make another Primary Care Physician selection.

[After initially selecting a Primary Care Physician, Members can transfer to different Primary Care Physicians if the physician patient relationship becomes unacceptable. The member can select another Primary Care Physician from Our [**Physician or** Practitioners Directory].

Transfer requests received within the first twenty-five (25) days of the month will be effective the first day of the following month. If we receive the request after the twenty-fifth (25th) day, then the change will be effective the first day of the second month following the request.]

STATEMENTS

No statement will void the coverage, or be used in defense of a claim under this Contract, unless it is contained in a writing signed by a Member, and We furnish a copy to the Member or to the Member's beneficiary.

All statements will be deemed representations and not warranties.

TERMINATION OF DEPENDENT COVERAGE

If an Employee fails to pay the cost of Dependent coverage, an Employee's Dependent coverage will end. It will end on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

A Dependent's coverage ends when the Dependent is no longer eligible. This happens to a Child at 12:01 a.m. on the date he attains the Contract's age limit, or marries, or when a step-child is no longer dependent on the Employee for support and maintenance. It happens to a Spouse when the marriage ends in legal divorce or annulment.

Also, Dependent coverage ends when the Employee's coverage ends.

Read this Contract carefully if Dependent coverage ends for any reason. Dependents may have the right to continue certain benefits for a limited time.

THE ROLE OF A MEMBER'S PRIMARY CARE PHYSICIAN

A Member's Primary Care Physician provides basic health maintenance services and coordinates a Member's overall health care. Anytime a Member needs medical care, the Member should contact his or her Primary Care Physician and identify himself or herself as a Member of this program.

In a Medical Emergency, a Member may go directly to the emergency room. If a Member does, then the Member must call his or her Primary Care Physician and Member Services within 48 hours. If a Member does not call within 48 hours, We will provide services only if We Determine that notice was given as soon as was reasonably possible.

[**THE ROLE OF THE CARE MANAGER.** The Care Manager will manage a Member's treatment for a Mental or Nervous Disorder, Substance Abuse, or Alcohol Abuse. A Member must contact the Care Manager or the Member's Primary Care Physician when a Member needs treatment for one of these conditions.]

XI. CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 as enacted, and later amended.

A Member may be eligible to continue his or her group health benefits under this Contract's **COBRA CONTINUATION RIGHTS (CCR)** section and under other continuation sections of this Contract at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR):** If a Member is eligible to continue his or her group health benefits under both this Contract's CCR and NJGCR sections, he or she may elect to continue under CCR, but cannot continue under NJGCR.

Continuation Under CCR and any other continuation section of this Contract:

If a Member elects to continue his or her group health benefits under both this Contract's CCR and any other continuation sections, the continuations:

a. start at the same time;
b. run concurrently; and
c. end independently on their own terms.

When covered under more than one continuation section, the Member:

a. will not be entitled to duplicate benefits; and
b. will not be subjected to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's plan. The Employee must contact his or her Employer to find out if:

a. the Employer is subject to the COBRA CONTINUATION RIGHTS section, and therefore;
b. the section applies to the Employee.

COBRA CONTINUATION RIGHTS

Important Notice

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Contract as:

a. an active, covered Employee;
b. the spouse of an active, covered Employee; or
c. the Dependent child of an active, covered Employee. Any person who becomes covered under this Contract during a continuation provided by this section is not ***a*** qualified continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if:

a. he or she was not terminated due to gross misconduct; and
b. he or she is not entitled to Medicare.

The continuation:

a. may cover the Employee and any other qualified continuee; and
b. is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:

a. the end of the 18 month continuation period; and
b. 60 days after the date the qualified continuee is determined to be disabled.

If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Employee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Covered

If an Employee dies while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility

If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Contract, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to the **When Continuation Ends.**

Concurrent Continuations

If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:

a. the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b. the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify the Employer, in writing, of:

a. the legal divorce or legal separation of the Employee from his or her spouse; or
b. the loss of dependent eligibility, as defined in this Contract, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities

The Employer must notify the qualified continuee, in writing, of:

a. his right to continue this Contract's group health benefits;
b. the monthly premium he or she must pay to continue such benefits; and
c. the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of:

a. the date a qualified continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hour; or
b. the date a qualified continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a covered Dependent child.

The Employer's Liability

The Employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, [Carrier], if:

a. the Employer fails to remit a qualified continuee's timely premium payment to Us on time, thereby causing the qualified continuee's continued group health benefits to end; or
b. the Employer fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give the Employer written notice that he or she elects to continue.

This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from the Employer as described above. And the qualified continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the qualified continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under this Contract on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the qualified continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

a. with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b. with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of:
   - the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
   - the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
c. with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d. with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e. the date this Contract ends;
f. the end of the period for which the last premium payment is made;
g. the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the qualified continuee;
h. the date he or she becomes entitled to Medicare.

A divorced spouse whose continued health benefits end as described above may elect to convert some of these benefits to an individual insurance policy. Read this Contract's Conversion Rights for Divorced Spouses section for details.

NEW JERSEY GROUP CONTINUATION RIGHTS

Important Notice

If An Employee's Group Benefits End

If an Employee's health coverage end due to termination of employment for a reason other than for cause, or reduction of work hours to below 25 hours per week, he or she may elect to continue such benefits for up to 12 months, subject to the **When Continuation Ends** section. At the Employee's option, he or she may elect to continue health coverage for any of his or her then insured Dependents whose coverage would otherwise end at this time. In order to continue health coverage for his or her Dependents, the Employee must elect to continue health coverage for himself or herself.

What The Employee Must Do

To continue his or her health coverage, the Employee must send a written request to the Employer within 30 days of the date of termination of employment or reduction of work hours. The Employee must also pay the first month's premium. The first premium payment must be made within 30 days of the date the Employee elects continuation.

The subsequent premiums must be paid to the Employer, by the Employee, in advance, at the times and in the manner We specify.

The monthly premium will be the total rate which would have been charged for the small group benefits had the Employee stayed insured under this Contract on a regular basis. It includes any amount that the Employer would have paid. And an additional charge of 2% of the total premium may be charged for the continued coverage.

If an Employee fails to give the Employer notice that he or she elects to continue, or fails to make any premium payment in a timely manner, he or she waives his or her continuation rights. All premium payments, except the first, will be considered timely if they are made within 31 days of the specified due dates.

The Continued Coverage

The Employee's continued coverage will be identical to the coverage he or she had when covered under this Contract on a regular basis. Any modifications made under this Contract will apply to similarly situated continuees. We do not ask for proof for insurability in order for an Employee to continue.

When Continuation Ends

A Member's continued health coverage end on the first of the following:

a. the date which is 12 months from the date the small group benefits would otherwise end;
b. the date the Member becomes eligible for Medicare;
c. the end of the period for which the last premium payment is made;
d. the date the Member becomes covered under another group medical plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Member;
e. with respect to a Member who becomes covered under another group medical plan which contains a limitation or exclusion with respect to a Pre-Existing Condition of the Member, the date such limitation or exclusion ends;
f. the date the Employer no longer provides any health benefit plans for any of the Employer's Employees or their eligible Dependents; or
g. with respect to a Dependent, the date he or she is no longer an eligible Dependent as defined in this Contract.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled

An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Contract for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage

To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Contract would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Contract on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

We will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.

If the Employer fails, after the timely receipt of the Employee's payment, to pay Us on behalf of such Employee, thereby causing the Employee's coverage to end; then such Employer will be liable for the Employee's benefits, to the same extent as, and in place of, Us.

When This Continuation Ends

These continued group health benefits end on the first of the following:

a. the end of the period for which the last payment is made, if the Employee stops paying.
b. the date the Member becomes employed and eligible or covered for similar benefits by another group plan, whether it be an insured or uninsured plan;
c. the date this Contract ends or is amended to end for the class of Employees to which the Employee belonged; or
d. with respect to a Dependent, the date he or she stops being an eligible Dependent as defined in this Contract.

EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS DURING A FAMILY LEAVE OF ABSENCE

Important Notice

This section may not apply to an Employer's plan. The Employee must contact his or her Employer to find out if:

- the Employer must allow for a leave of absence under Federal law and, therefore
- the section applies to the Employee.

If An Employee's Group Health Coverage Ends

Group health coverage may end for an Employee because he or she ceases Full-Time work due to an approved leave of absence. Such leave of absence must have been granted to allow the Employee to care for a sick family member or after the birth or adoption of a child. If so, his or her medical care coverage will be continued. Dependents' insurance may also be continued. The Employee will be required to pay the same share of premium as before the leave of absence.

When Continuation Ends

Insurance may continue until the earliest of:

a. the date the Employee returns to Full-Time work
b. the end of a total period of 12 weeks in any 12 month period, or
c. the date on which the Employee's coverage would have ended had the Employee not been on leave.

A DEPENDENT'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If an Employee dies, any of his or her Dependents who were insured under this Contract may elect to continue coverage. Subject to the payment of the payment of the required premium, coverage may be continued until the earlier of:

a. 180 days following the date of the Employee's death; or
b. the date the Dependent is no longer eligible under the terms of this Contract.

CONVERSION RIGHTS FOR DIVORCED SPOUSES

F AN EMPLOYEE'S MARRIAGE ENDS

If an Employee's marriage ends by legal divorce or annulment, the group health coverage for his or her former spouse ends. The former spouse may convert to an individual policy during the conversion period. The former spouse may insure under his or her individual policy any of his or her Dependent children who were insured under this Contract on the date the group health coverage ends. See exceptions below.

Exceptions

No former spouse may use this conversion right:

- unless he or she has been insured under this Contract for at least 3 months;
- if he or she is eligible for Medicare;
- if it would cause him or her to be overinsured; or
- [• if he or she permanently relocates outside the Service Area.]

This may happen if the spouse is covered or eligible for coverage providing similar benefits provided by any other plan, insured or not insured. We will determine if overinsurance exists using Our standards for overinsurance.

OW AND WHEN TO CONVERT

The conversion period means the 31 days after the date group health coverage ends. The former spouse must apply for the individual policy in writing and pay the first premium for such policy during the conversion period. Evidence of insurability will not be required.

THE CONVERTED CONTRACT

The individual policy will provide the medical benefits that We are required to offer. The individual policy will take effect on the day after group health coverage under this Contract ends.

After group health coverage under this Contract ends, the former spouse and any children covered under the individual policy may still be paid benefits under this Contract. If so, benefits to be paid under the individual policy will be reduced by the amount paid or the reasonable cash value of services provided under this Contract.

XII. RIGHT TO RECOVERY—THIRD PARTY LIABILITY

As used in this section:

"Covered Person" means an Employee or Dependent, including the legal representative of a minor or incompetent, insured by this Contract.

"Reasonable pro-rata Expenses" are those costs such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than Us, the Employer or the Covered Person.

If a Covered Person receives services or supplies from Us or makes a claim to Us for benefits under this Contract prior to receiving payment from a third party or its insurer, the Covered Person must agree, in writing, to repay Us from any amount of money they receive from the third party, or its insurer for an Illness or Injury.

We shall require the return of health benefits paid or the reasonable cash value of all services and supplies arranged [or provided] for an Illness or Injury, up to the amount a Covered Person receives for that Illness or Injury through:

a. a third party settlement;
b. a satisfied judgment; or
c. other means.

We will only require such payment when the amounts received through such settlement, judgment or otherwise, are specifically identified as amounts paid for health benefits for which We have paid benefits or arranged [or provided] services or supplies.

The repayment will be equal to the amount of benefits paid by Us or the reasonable cash value of services and supplies arranged or provided by Us. However, the Covered Person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment from the repayment to Us.

The repayment agreement will be binding upon the Covered Person whether:

a. the payment received from the third party, or its insurer, is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement, or
b. the third party, or its insurer, has admitted liability for the payment.

We will not pay any benefits under this Contract or arrange [or provide] services and supplies to or on behalf of a Covered Person, who has received payment in whole or in part from a third party, or its insurer for past or future charges for an Illness or Injury, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

XIII. EFFECT OF MEDICARE ON THE COVERAGE

A. ELIGIBILITY PROVISIONS FOR MEMBERS AGE 65 OR MORE WHO ARE ELIGIBLE FOR MEDICARE.

"Medicare" means Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act, as amended from time to time.

"Part A of Medicare" means the program of Hospital Insurance for the Aged and Disabled under Part A of Medicare.

A Member age 65 or more who is eligible for Part A of Medicare may have this coverage as that person's primary benefit program, pursuant to the Federal Age Discrimination in Employment Act, as amended. The *[Group Health Care Coverage]* ***coverage*** for such Member will continue only while the Member is meeting the following conditions:

1. In the case of an Employee, the Employee is not retired.
2. In the case of a *[Qualified]* Dependent, the Member is the *[Qualified]* Dependent of an Employee who meets condition (1) above.
3. The Member has not elected Medicare, in writing, as the primary benefit program.

B. SPECIAL PROVISIONS FOR OTHER MEMBERS WHO ARE ELIGIBLE FOR MEDICARE.

For a member who is eligible for Medicare and to whom section A above does not apply, this coverage will continue only subject to the following conditions:

1. The Member, if eligible, has enrolled in Parts A and B of Medicare.
2. The Member has completed such consents, releases, assignments and other documents reasonably requested by Us to obtain or assure Medicare reimbursements.

C. *[BENEFITS]* *SERVICES AND SUPPLIES*.

The *[benefits]* ***services and supplies*** of this coverage provided to Members are not designed to duplicate any benefit for which they are enrolled and entitled under Medicare. All sums payable under Medicare for services and supplies that are provided under this coverage will be payable to, and retained by, Us.

EXHIBIT H

PART 1

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.]

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and listed in the Forumulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

*[**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Covered Person can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.]*

*[**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.]*

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

*[A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill which is **not** obtained through the Mail Order Program is:]*

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

The Co-Payment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drug None
- for Brand Name Drugs $5.00

[After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.]

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:

a. prescribed by a Practitioner (except for insulin);
b. *[dispensed by a participating Pharmacy;]* ***(Reserved) and***
c. needed to treat an Illness or Injury ***or Mental and Nervous Conditions and Substance Abuse***; *[and
d. accepted as safe and effective by the health community.]*

Such charges will not include charges made for more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. *[a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and]* ***(Reserved)***
c. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:

a. Charges to administer a Prescription Drug.
b. Charges for:
   - immunization agents
   - biological sera
   - blood or blood plasma.
c. Charges for a Prescription Drug which is:
   - labeled "Caution—limited by Federal Law to investigationa use"; or
   - experimental.
d. Charges for refills in excess of that specified by the prescribin Practitioner.
e. Charges for refills dispensed after one year from the original dat of the prescription.
f. Charges for drugs, except insulin, which can be obtained legall without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or give to the Covered Person, in whole or in part, while confined in
   - a Hospital
   - a rest home
   - a sanitarium
   - an Extended Care Facility
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
h. Charges for:
   - therapeutic devices or appliances
   - hypodermic needles
   - syringes
   - support garments

and other non-medical substances, regardless of their intended use.
i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs containing nicotine or other smoking deterrent medication.
k. Charges for topical dental Fluorides.
l. Charges for any drug used in connection with baldness.
*[l.]***m.* Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
*[m.]***n.* Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
*[n.]***o.* Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
*[o.]***p.* Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
*[p.]***q.* Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

EXHIBIT H

PART 2

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.]

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner: What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic drugs mean:
a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength of concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:
a. Legend Drugs;
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:

• for Generic Drugs	$5.00
• for Brand Name Drugs	$10.00

After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a. prescribed by a Practitioner (except for insulin);
b. dispensed by a Participating Pharmacy; ***and***
c. needed to treat an Illness or Injury ***or Mental and Nervous Conditions and Substance Abuse****[; and
d. accepted as safe and effective by the health community.]*

Such charges will not include charges made for more than:
a. the greater of a 30 day supply or 100 unit doses; and
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a. Charges to administer a Prescription Drug.
b. Charges for:
- immunization agents
- biological sera
- blood or blood plasma.

c. Charges for a Prescription Drug which is:
- labeled "Caution—limited by Federal Law to investigational use"; or
- experimental.

d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Presciption Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
- a Hospital
- a rest home
- a sanitarium
- an Extended Care Facility
- a Substance Abuse Center
- an alcohol abuse or mental health center
- a convalescent home
- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.
j. Charges for drugs containing nicotine or other smoking deterrent medication.
k. Charges for topical dental Fluorides.
l. Charges for any drug used in connection with baldness.
*[l.]***m.*** Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.
*[m.]***n.*** Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.
*[n.]***o.*** Charges for drugs dispensed to a Covered Person while on active duty in any armed force.
*[o.]***p.*** Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.
*[p.]***q.*** Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

EXHIBIT H

PART 3

RIDER FOR PRESCRIPTION DRUG INSURANCE

Policyholder:

Group Policy No:

Effective Date:

The **Prescription Drug** section of the **COVERED CHARGES** provision of the **HEALTH BENEFITS INSURANCE** section is replaced with the following:

[[Carrier] covers drugs which require a Practitioner's prescription which are obtained while confined as an Inpatient in a Facility. But [Carrier] only covers drugs which are approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration. In no event will [Carrier] pay for drugs labeled: "Caution—Limited by Federal Law to Investigational Use". And [Carrier] excludes drugs that can be bought without a prescription, even if a Practitioner orders them.]

This Prescription Drug insurance will pay benefits for covered drugs, prescribed by a Practitioner. What [Carrier] pays and the terms of payment are explained below.

DEFINITIONS

Brand Name Drugs mean:
a. drugs as determined by the Food and Drug Administration and listed in the Formulary of the State in which they are dispensed; and
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic drugs mean:
a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;
b. drugs which are used unless the Practitioner prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

*[**Mail Order Program** means a program agreed to by [ABC] and a Participating Pharmacy under which a Covered Person can obtain Maintenance Drugs from a Participating Pharmacy by ordering the drugs through the mail.]*

*[**Maintenance Drug** means only a Prescription Drug used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders.]*

*[**Participating Pharmacy** means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.]*

Prescription Drug means:
a. Legend Drugs
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Practitioner.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

CO-PAYMENT

[A Covered Person must pay the appropriate Co-Payment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Co-Payment must be paid before the Policy pays any benefit for the Prescription Drug. The Co-Payment for each prescription or refill is:]

• for Generic Drugs	None
• for Brand Name Drugs	$5.00

[After the Co-Payment is paid, [Carrier] will pay the Covered Charge in excess of the Co-Payment for each Prescription Drug dispensed by a Participating Pharmacy while the Covered Person is insured. What [Carrier] pays is subject to all the terms of the Policy.]

COVERED DRUGS

The Policy only pays benefits for Prescription Drugs which are:
a. prescribed by a Practitioner (except for insulin);
b. *[dispensed by a Participating Pharmacy for take-home use;]* ***(Reserved); and***
c. needed to treat an Illness or Injury ***or Mental and Nervous Conditions and Substance Abuse****[; and
d. accepted as safe and effective by the health community.]*

Such charges will not include charges made for more than:
a. *[a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and]* ***(Reserved)***
b. the amount usually prescribed by the Covered Person's Practitioner.

A charge will be considered to be incurred at the time the Prescription Drug is received.

POLICYHOLDER LIABILITY

The Policyholder will be liable to [Carrier] for any Prescription Drug benefit paid to a person after his insurance ends, except as stated in the **Extended Health Benefit** section of the Policy.

EXCLUSIONS

[Carrier] will not pay for any of the following:
a. Charges to administer a Prescription Drug.
b. Charges for:
   • immunization agents
   • biological sera
   • blood or blood plasma.
c. Charges for a Prescription Drug which is:
   • labeled "Caution—limited by Federal Law to investigational use"; or
   • experimental.
d. Charges for refills in excess of that specified by the prescribing Practitioner.
e. Charges for refills dispensed after one year from the original date of the prescription.
f. Charges for drugs, except insulin, which can be obtained legally without a Practitioner's prescription.
g. Charges for a Prescription Drug which is to be taken by or given to the Covered Person, in whole or in part, while confined in:
   • a Hospital
   • a rest home
   • a sanitarium
   • an Extended Care Facility
   • a Substance Abuse Center
   • an alcohol abuse or mental health center
   • a convalescent home

- a nursing home

or similar institution.

h. Charges for:
- therapeutic devices or appliances
- hypodermic needles
- syringes
- support garments

and other non-medical substances, regardless of their intended use.

i. Charges for vitamins, except Legend Drug vitamins.

j. Charges for drugs containing nicotine or other smoking deterrent medication.

k. Charges for topical dental Fluorides.

l. Charges for any drug used in connection with baldness.

*[l.]***m.*** Charges for drugs needed due to conditions caused, directly or indirectly, by a Covered Person taking part in a riot or other civil disorder; or the Covered Person taking part in the commission of a felony.

*[m.]***n.*** Charges for drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war.

*[n.]***o.*** Charges for drugs dispensed to a Covered Person while on active duty in any armed force.

*[o.]***p.*** Charges for drugs for which there is no charge. This usually means drugs furnished by the Covered Person's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But, if a charge is made, and [Carrier] is legally required to pay it, [Carrier] will.

*[p.]***q.*** Charges for drugs needed due to an on-the-job or job-related Injury or Illness; or conditions for which benefits are payable by Workers' Compensation, or similar laws.

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

EXHIBIT I

RIDER FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE BENEFITS

Policyholder:

Group Policy No:

Effective Date:

The **Mental and Nervous Conditions and Substance Abuse** section of the **COVERED CHARGES WITH SPECIAL LIMITATIONS** provision of the **HEALTH BENEFITS INSURANCE** section of the Policy is replaced with the following.

The Co-Payment, Cash Deductible, Co-Insurance and Co-Insurance cap provisions of this Rider are independent of similar provisions of the **Health Benefits** section of the Policy. Charges incurred for the treatment of Mental and Nervous Conditions and Substance Abuse must be considered under the terms of this Rider and cannot be considered under the **Health Benefits** section of the Policy.

PRE-CERTIFICATION REQUIREMENTS

The Covered Person must notify [XYZ] whenever he or she requires Inpatient or Outpatient care or treatment of Mental and Nervous Conditions or Substance Abuse. [XYZ], a health care review organization, reviews and precertifies all mental health and Substance Abuse treatment on [Carrier's] behalf. The times and manner in which [XYZ] must be notified are described below. If the Covered Person does not comply with these requirements, [Carrier] *[reduces what it]* ***will not*** pay*[s]* for ***the*** care and treatment of Mental and Nervous conditions and Substance Abuse *[as a penalty]*. See the **Penalty for Non-Compliance with Pre-Certification Requirements** section of this Rider.

NON-EMERGENCY SITUATIONS

All non-emergency care or treatment **must** be reviewed by [XYZ] **before** it occurs. The Covered Person or his or her Practitioner must notify [XYZ] and request a review. They may do this by calling the [XYZ] 24 hour toll-free number that is listed [in the Covered Person's materials].

EMERGENCY SITUATIONS

In an emergency situation, [XYZ] must be notified within [24 hours] of care or treatment. But, if the Covered Person or his or her Practitioner is unable to call [XYZ] in the allotted amount of time, the Covered Person or his or her Practitioner must call [XYZ] as soon as reasonably possible.

Emergency means an Illness or Injury that requires a Covered Person to seek immediate Medically Necessary and Appropriate care or treatment under circumstances or at locations which reasonably preclude the Covered Person from obtaining care from an [XYZ] referred provider.

In both emergency and non emergency situations, when [XYZ] receives the notice and request for utilization review, they evaluate:

a. the Medical Necessity and Appropriateness;
b. the type of service involved;
c. the appropriate level of care required; and
d. the length of treatment.

Upon evaluation, [XYZ] will develop a treatment plan and refer the Covered Person to a specific mental health provider. [XYZ] may substitute alternate forms of care in lieu of inpatient care.

BENEFITS FOR MENTAL AND NERVOUS CONDITIONS AND SUBSTANCE ABUSE

[Carrier] will pay benefits for the Covered Charges a Covered Person incurs for the treatment of Mental and Nervous Conditions and Substance Abuse, as described below.

Co-Insurance

The Co-Insurance listed below is the percentage of a Covered Charge that the Covered Person must pay to a provider.

For Inpatient services certified ***as medically or clinically necessary*** by [XYZ]	None
For Inpatient services not certified by [XYZ]	100%
For Outpatient services certified ***as medically or clinically necessary*** by [XYZ]	None
For Outpatient services not certified by [XYZ]	100%

Co-Payments

Each Covered Person must pay a Co-Payment of *[*$150*]* for each day of Inpatient care up to a maximum of *[*$750*]* per confinement, subject to a maximum of *[*$1,500*]* Co-Payment per Calendar Year.

Each Covered Person must pay a Co-Payment of [$15] to the [XYZ] referred provider for each Outpatient visit. [Carrier] pays benefits for Outpatient Covered Charges in excess of the Co-Payment, less any applicable Co-Insurance.

Benefit Limits

Under this rider, [Carrier] only covers:

a. 30 days of Inpatient care per Calendar year; and
b. 20 Outpatient visits per Calendar year.

Each one day of Inpatient care may be exchanged for 2 Outpatient visits.

PENALTY FOR NON-COMPLIANCE WITH PRE-CERTIFICATION REQUIREMENTS

[As a penalty for non-compliance with pre-certification requirements, [Carrier] reduces what it pays for Covered Charges to 50% of what it would otherwise pay if:]

a. the Covered Person does not request a review in the times and manner described above;
b. the Covered Person's treatment does not comply with the treatment plan;
c. the Covered Person goes to a provider whose services were not referred by [XYZ]; or
d. [XYZ] does not confirm the need for such care or treatment.

APPEALS PROCEDURE

[*If the Covered Person or his or her attending Practitioner does not agree with the outcome of the [XYZ] review, the case will be immediately referred to a [XYZ] Practitioner who will discuss the case directly with the attending Practitioner. If an agreement is not reached, the case will be internally reviewed by a staff psychiatrist who may request that a local case manager see the Covered Person, or may discuss the case again with the attending Practitioner. This may involve a visit to the Facility in question and a clinical interview with the Covered Person and/or the family. If there is not agreement at that time, the Covered Person may appeal directly to [Carrier].*]

This rider is part of the Policy. Except as stated above, nothing in this rider changes or affects any other terms of the Policy.

[Carrier should insert Standard Rider Closure.]

EXHIBIT J

PART 1

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury ***or Mental or Nervous Condition*** by the Food and Drug Administration. In no event will We *[pay]* ***provide [or arrange]*** for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; ***and***
b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed:
b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and
c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program *[agreed to by [ABC] and a Participating Pharmacy]* under which a Member can obtain *[Maintenance]* Drugs from a Participating Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of the following chronic medical conditions*[: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders]*.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs
b. compound medications of which at least one ingredient is a Legend Drug;
c. insulin; and
d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill which is **not** obtained through the Mail Order Program is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

The Copayment for each prescription or refill which is obtained through the Mail Order Program is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin)
b. dispensed by a Participating Pharmacy; ***and***
c. needed to treat an Illness or Injury ***or Mental or Nervous Condition****[; and
d. accepted as safe and effective by the health community]*.

Such prescription or refill will not include a prescription or refill that is more than:

a. the greater of a 30 day supply or 100 unit doses for each prescription or refill which is not obtained through the Mail Order Program;
b. a 90 day supply of a Maintenance Drug obtained through the Mail Order Program; and
c. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends, except as stated in the **Extended Health Benefit** section of the Contract.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.
b. Immunization agents.
c. Biological sera.
d. Blood or Blood Plasma.
e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.
f. Refills in excess of the amount specified by the prescribing Participating Provider.
g. Refills dispensed after one year from the original date of the prescription.
h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.
i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution
j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.
k. Vitamins, except for Legend Drug vitamins.
l. Drugs containing nicotine or other smoking deterrent medication.
m. Topical dental Fluorides.
n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.
o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.
p. Drugs dispensed to a Member while on active duty in any armed force.
q. Drugs for which there is no charge. This usually means drugs furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will

r. Drugs needed due to an on-the-job related Injury or Illness ***or Mental or Nervous Condition***; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider]

EXHIBIT J

PART 2

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury ***or Mental or Nervous Condition*** by the Food and Drug Administration. In no event will We *[pay]* ***provide [or arrange]*** for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; ***and***

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

- for Generic Drugs $5.00
- for Brand Name Drugs $10.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin);

b. dispensed by a Participating Pharmacy; ***and***

c. needed to treat an Illness or Injury ***or Mental or Nervous Condition****[; and

d. accepted as safe and effective by the health community]*.

Such prescription or refill will not include a prescription or refill that is more than amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends*[, except as stated in the **Extended Health Benefit** section of the Contract]*.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

p. Drugs dispensed to a Member while on active duty in any armed force.

q. *[Drugs for which there is no charge. This usually means drugs]* ***Drugs*** furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r. Drugs needed due to an on-the-job related Injury or Illness ***or Mental or Nervous Condition***; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider]

EXHIBIT J

PART 3

RIDER FOR PRESCRIPTION DRUG COVERAGE

Contract Holder:

Group Contract No:

Effective Date:

The Prescription Drug section of the **Covered Services and Supplies** Section of the HMO Contract is replaced with the following:

We cover drugs which require a Participating Provider's prescription which are obtained while confined as an Inpatient. But We only cover drugs which are approved for treatment of the Member's Illness or Injury ***or Mental or Nervous Condition*** by the Food and Drug Administration. In no event will We *[pay]* ***provide [or arrange]*** for drugs labeled: "Caution—limited by Federal Law to Investigational Use". And We do not cover drugs that can be obtained without a prescription, even if a Participating Provider orders them.

This Prescription Drug Coverage will provide benefits for covered drugs, prescribed by a Participating Provider. What We arrange [or provide] and the terms of the coverage are explained below.

DEFINITIONS

Brand Name Drugs mean:

a. drugs as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed; ***and***

b. protected by the trademark registration of the pharmaceutical company which produces them.

Generic Drugs mean:

a. therapeutically equivalent drugs, as determined by the Food and Drug Administration and as listed in the Formulary of the State in which they are dispensed;

b. drugs which are used unless the Participating Provider prescribes a Brand Name Drug; and

c. drugs which are identical to the Brand Name Drugs in strength or concentration, dosage form and route of administration.

Mail Order Program means a program *[agreed to by [ABC] and a Participating Pharmacy]* under which a Member can obtain *[Maintenance]* Drugs from a Participating Pharmacy by ordering the drugs through the mail.

Maintenance Drug means only a Prescription Drug used for the treatment of the following chronic medical conditions*[: chronic obstructive pulmonary disease; clotting disorders; congestive heart failure; coronary artery disease (angina); diabetes (oral agents only), glaucoma; hypertension; thyroid disease; seizure disorders]*.

Participating Pharmacy means a licensed and registered pharmacy operated by [ABC] or with whom [ABC] has signed a pharmacy service agreement.

Prescription Drug means:

a. Legend Drugs;

b. compound medications of which at least one ingredient is a Legend Drug;

c. insulin; and

d. any other drug which by law may only be dispensed with a prescription from a Participating Provider.

Legend Drugs means any drug which must be labeled: "Caution—Federal Law prohibits dispensing without a prescription."

Copayment

A Member must pay the appropriate Copayment shown below for each Prescription Drug each time it is dispensed by a Participating Pharmacy. The Copayment must be paid before the Contract provides any benefit for the Prescription Drug. The Copayment for each prescription or refill is:

- for Generic Drugs None
- for Brand Name Drugs $5.00

After the Copayment is paid, We will provide the Prescription Drug. The Prescription Drugs which are covered are subject to all the terms of the Contract.

COVERED DRUGS

The Contract only provides benefits for Prescription Drugs which are:

a. prescribed by a Participating Provider (except for insulin)

b. dispensed by a Participating Pharmacy; ***and***

c. needed to treat an Illness or Injury ***or Mental or Nervous Condition****[; and

d. accepted as safe and effective by the health community]*.

Such prescription or refill will not include a prescription or refill that is more than:

a. a 90 day supply of a Maintenance Drug *[obtained through the Mail Order Program]*; and

b. the amount usually prescribed by the Member's Participating Provider.

A supply will be considered to be furnished at the time the Prescription Drug is received.

Contract Holder Liability

The Contract Holder will be liable to Us for the cost of any Prescription Drug provided to a person after his or her coverage ends*[, except as stated in the **Extended Health Benefit** section of the Contract]*.

NON-COVERED SERVICES AND SUPPLIES

We will not provide for any of the following Services or Supplies:

a. Administration of a Prescription drug.

b. Immunization agents.

c. Biological sera.

d. Blood or Blood Plasma.

e. Prescription Drugs labeled "Caution—limited by Federal Law to investigational use" or experimental.

f. Refills in excess of the amount specified by the prescribing Participating Provider.

g. Refills dispensed after one year from the original date of the prescription.

h. Drugs, except insulin, which can be obtained legally without a Participating Provider's prescription.

i. Prescription Drugs which are taken by or given to a Member, in whole or in part, while confined in:
   - a Hospital
   - a rest home
   - a sanitarium
   - a Skilled Nursing Center
   - a Substance Abuse Center
   - an alcohol abuse or mental health center
   - a convalescent home
   - a nursing home

   or similar institution

j. Therapeutic devices or appliances, hypodermic needles, syringes, support garments and other non-medical substances, regardless of their intended use.

k. Vitamins, except for Legend Drug vitamins.

l. Drugs containing nicotine or other smoking deterrent medication.

m. Topical dental Fluorides.

n. Drugs needed due to conditions caused, directly or indirectly, by a Member taking part in a riot or other civil disorder; or the Member taking part in the commission of a felony.

o. Drugs needed due to conditions caused directly or indirectly, by declared or undeclared war or an act of war.

p. Drugs dispensed to a Member while on active duty in any armed force.

q. *[Drugs for which there is no charge. This usually means drugs]* ***Drugs*** furnished by the Member's employer, labor union, or similar group in its medical department or clinic; a Hospital or clinic owned or run by any government body; or any public program, except Medicaid, paid for or sponsored by any government body. But if a charge is made, and We are legally required to pay it, We will.

r. Drugs needed due to an on-the-job or job related Injury or Illness ***or Mental or Nervous Condition***; or conditions for which benefits are payable by Worker's Compensation, or similar laws.

This rider is part of the Contract. Except as stated above, nothing in this rider changes or affects any other terms of the Contract.

[Carrier should insert Standard Rider]

EXHIBIT K

PART 1

EXPLANATION OF BRACKETS*-POLICY FORMS* (PLANS A, B, C, D, E)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Policyholder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text. Examples include: use of Planholder, PPO, and POS text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in the policy forms.

1. Dividend text which appears both on the Face Page and in the General Provisions should only be included by carriers that *[are organized as mutual companies]* ***could pay dividends***.
2. Deductible, Co-Insurance, and Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
3. The refund formula specified on the Premium Amounts provision of the General Provisions may be modified to specify alternate methods of calculation.
4. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy—Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
5. The Notice of Loss provision of the Claims Provisions may be omitted at the option of the Carrier.
6. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the *[Carrier]* ***Employer***. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
7. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.

***(RIDERS)**

All text which is enclosed in brackets [ ] is variable.

Some areas of variability are self-explanatory. Examples include: [Carrier], [XYZ], and [ABC].

Some areas of variability are noted with brief explanations on the text. An example is the rider closure.

The Co-Payment amounts in the Mental and Nervous Conditions and Substance Abuse rider may vary to be consistent with any other Co-Payment amounts allowed for HMO plans.

The Appeals Procedure in the Mental and Nervous Conditions and Substance Abuse rider may vary to conform to a carrier's and/or health care review organization's procedure.*

EXHIBIT K

PART 2

EXPLANATION OF BRACKETS (HMO PLAN)

All text which is enclosed in brackets [ ] is variable. Such text may generally be categorized in four ways.

a. Some areas of variability are self-explanatory. Examples include: [Carrier], [Contract Holder], and [ABC].
b. Some areas of variability are noted with brief explanations within the text.
c. Some areas of variability are intended to allow for flexibility in terms of a carrier's administrative practices.
d. Some areas of variability are subject to ranges and parameters specified in statute and/or regulation.

Areas of variability, which may require clarification and explanation as to use, are explained below. The order of the list is consistent with the order of appearance in Contract forms.

1. Co-Payments may be elected by the Employer, subject to the availability specified in regulation.
2. Actively At Work requirement can be deleted. Federally Qualified HMOs cannot apply Active Work Requirements.
3. The Generic Drug definition can be deleted if not needed.
4. The Pre-Existing Condition exclusion can be deleted. Federally Qualified HMOs cannot apply the Pre-Existing Condition Exclusion.
5. OB/GYNs can be considered Primary Care Physicians.
6. Eligible class references can be removed.
7. The Waiting Period provision of the Employee Coverage Provision may be omitted or included at the option of the Carrier. If included, the period may not exceed 6 months and must satisfy the requirements of regulation.
8. The date Employee and Dependent coverage ends may vary to accommodate Employer and/or Carrier administration practices. For example, coverage may end immediately or may end at the end of the month following a termination event.
9. Small Claims Waiver can be deleted.
10. Percentage participation requirements as noted in the Participation Requirements and in the Termination of the Policy—Renewal Privilege provisions of the General Provisions may be determined by the Carrier, provided the requirements comply with the requirements permitted in Statute and regulation.
11. Transfer of Primary Care Physician can occur according to carrier administration.

EXHIBIT L

PART 1

PATIENT INSTRUCTIONS FOR HCFA 1500

To request reimbursement for medical expenses; please complete the attached form blocks 1 through 13. To assist you, follow the instructions below. Please remember that all statements must be accurate.

Please bring this claim form with you at the time the medical services are rendered. The provider of service is responsible for completing blocks 14 through 33.

When requesting reimbursement, you should also attach copies of itemized bills and receipts for the medical services for which you are submitting a claim.

PATIENT INSTRUCTIONS

Block 1

Place an "X" in the appropriate block which identifies the type of insurance program that applies to the claim.

Block 1a

Enter the Social Security number or unique identification number assigned by the insurance carrier or the individual in whose name the insurance is carried.

Block 2

Enter the patient's last name, first name and middle initial.

Block 3

Enter the patient's date of birth in a MMDDYY format. Example: 01 12 94 for January 12, 1994. Place an "X" in the appropriate gender box.

Block 4

Enter the last name, first name and middle initial of the individual in whose name the insurance is carried.

Block 5

Enter the mailing address of the patient.

Block 6

Place an "X" in the appropriate box which identifies the relationship of the patient to the insured individual.

Block 7

Enter the mailing address of the individual who holds the insurance if it is different from the patient's address listed in Block 5. Otherwise, enter the word "SAME".

Block 8

Place an "X" in the appropriate box which identifies the patient's marital status. Also, place an "X" in the appropriate box which identifies the employment/student status of the patient.

Block 9

If the patient has other insurance, enter the last name, first name and middle initial of the covered individual if it is different from that shown in Block 4. Otherwise, enter the word SAME.

Block 9a

Enter the other insurance carrier's identification number or unique code assigned by the carrier to identify the group or policy under which the individual in Block 9 is covered.

Block 9b

Enter the date of birth or the individual (listed in Block 9) in a MMDDYY format. Example: 011294 for January 12, 1994.

Enter an "X" in the appropriate gender box.

Block 9c

Enter the name of the individual's (listed in Block 9) employer or school name.

Block 9d

Enter the name of the insurance program covering the individual in Block 9.

Block 10a through 10c

Place an "X" in the appropriate box to indicate whether the patient's condition is related to employment, auto accident, or other accident. For auto accidents, indicate the states abbreviation in which the accident occurred (e.g. New Jersey—NJ).

Block 10d

This field is not required.

Block 11

Enter the identification or unique code assigned by the carrier to identify the group or policy under which the individual is covered.

Block 11a

Enter the individual's (listed in Block 4) birthdate in a MMDDYY format. Example: 011294 represents January 12, 1994.

Place an "X" in the appropriate gender box.

Block 11b

Enter the individual's (listed in Block 4) **employer name or school name.**

Block 11c

Enter the name of the insurance program covering the individual in Block 4.

Block 11d

Place an "X" in the appropriate box. If the answer is YES, complete sections 9a-9d.

Block 12

The patient's signature in this field authorizes release of medical information necessary to process this claim. The patient or an authorized representative should sign and date this block unless the signature is on file in the provider's office/facility.

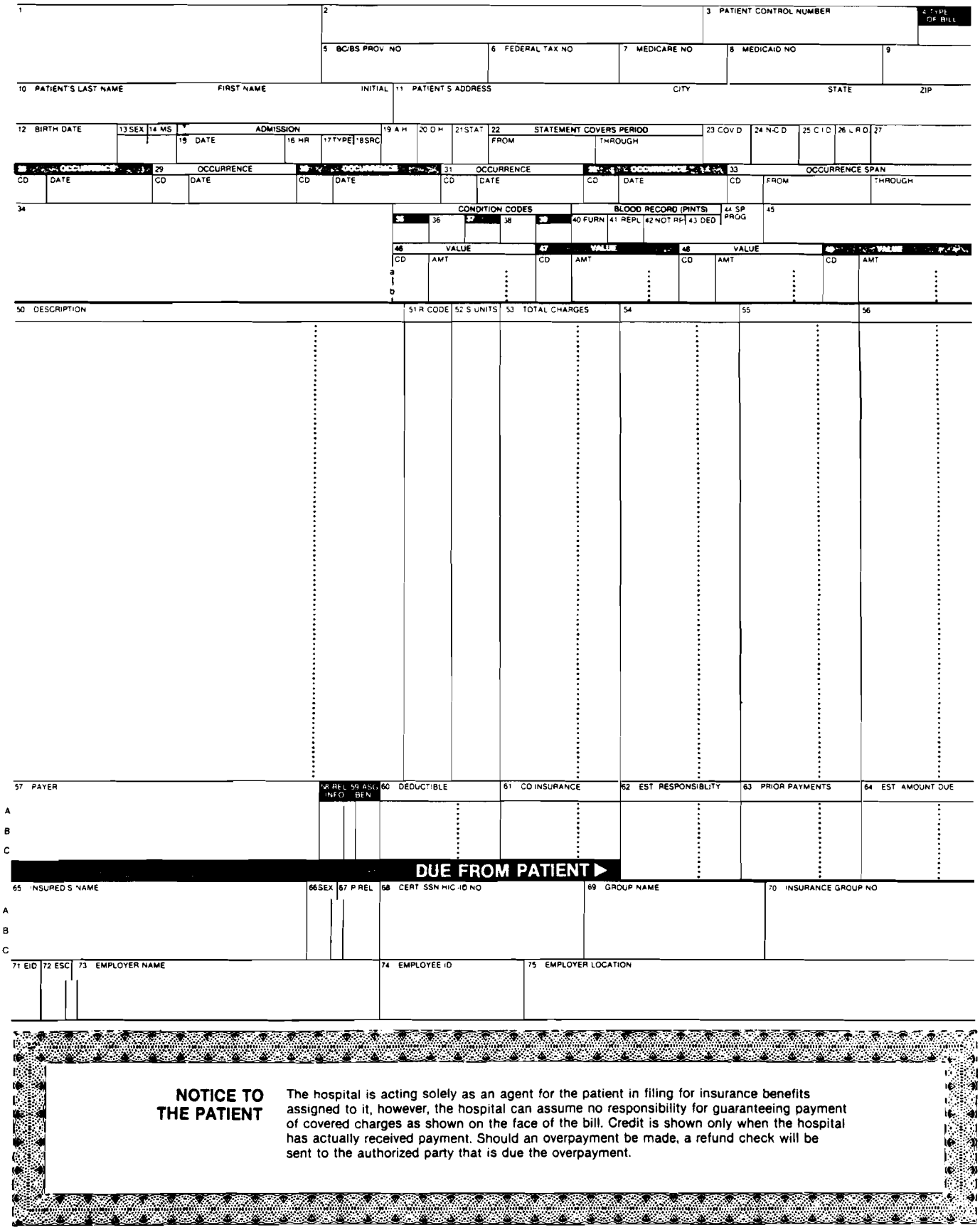
Block 13

The signature in this block authorizes the insurance carrier to release insurance benefits directly to the provider of the services listed in Block 33.

EXHIBIT L

PART 2

APPROVED OMB NO 0938-0279



NOTICE TO THE PATIENT

The hospital is acting solely as an agent for the patient in filing for insurance benefits assigned to it, however, the hospital can assume no responsibility for guaranteeing payment of covered charges as shown on the face of the bill. Credit is shown only when the hospital has actually received payment. Should an overpayment be made, a refund check will be sent to the authorized party that is due the overpayment.

UB-82 HCFA-1450

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT? PLACE (State) ☐ YES ☐ NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ___ . __ 3. ___ . __ 2. ___ . __ 4. ___ . __		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS / MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#		

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

EXHIBIT M

Carrier:
Group Medical Claims
PO Box XXXXX
Anywhere, New Jersey XXXXX

GE 0094

Annual Family Profile and Claim Notice

Send this form once each calendar year to the address above with your first claim of the year. If any information changes, send a new one. If you have questions about claims or need forms, call XXX-XXX-XXXX

Employer name	Employer phone number	Plan/Policy Number

Check one ☐ Active employee ☐ Retired employee ☐ Continued individual

Employee information

Name	Date of birth	Social Security Number

Address	City	State	ZIP	Home phone number

Do you have another employer? ☐Yes ☐No	If "Yes," please give name of other employer	Other employer's phone number

Are you covered by another group plan? ☐Yes ☐No	If "Yes," please give name of carrier	Plan number	Other carrier's phone number

Spouse information

Name	Date of birth	Social Security Number

Name and address of spouse's employer	Phone number of spouse's employer

Is spouse covered by another group plan? ☐Yes ☐No	If "Yes," please give name of other carrier	Plan number	Other carrier's phone number

Dependent children information

Name	Date of birth ☐Male ☐Female	Social Security No.	Relation to employee	Handicapped ☐Yes ☐No

List any additional dependent children on a separate page and attach it to this form.
If any child is over the limiting age and a full-time student, please give the information requested below.

Name	Name of school	Address of school

If any child is covered by another group plan, please give the information requested below.

Name	Insured person	Name of carrier	Plan number

I authorize any provider, insurer, or other organization to release any information regarding the medical history, treatment, or benefits payable for this claim to the plan administrator or its authorized agent for the purpose of determining benefits payable.

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

Signature of employee	Signature of patient if other than minor child	Date

SEH-FP-7/93

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

(a)

NEW JERSEY SMALL EMPLOYER HEALTH BENEFITS PROGRAM

Declaration and Approval of Reinsuring or Risk-Assuming Carrier Status

Adopted New Rules: N.J.A.C. 11:21-14

Proposed: September 3, 1993 pursuant to P.L. 1993, c.162, §16 (see 25 N.J.R. 4572(a), October 4, 1993).

Adopted: October 14, 1993 by Samuel F. Fortunato, Commissioner, Department of Insurance.

Filed: October 15, 1993 as R.1993 d.551, **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. 17:1-8.1, 17:1C-6(e), 17B:27A-34 and 17B:27A-46.

Effective Date: October 15, 1993.

Expiration Date: October 15, 1998.

These new rules were proposed and are being adopted pursuant to the procedures of P.L. 1993, c.162, s.16 ("Section 16"), as therein authorized. Accordingly, notice of the proposal of these new rules was sent for publication to three papers of general circulation in New Jersey, and simultaneously mailed to all known interested parties when submitted to the Office of Administrative Law for publication in the October 4, 1993 New Jersey Register.

Pursuant to Section 16d, all interested parties were provided at least a 15-day comment period. As set forth in the notice of proposed new rules, the written comment period ended on September 20, 1993. No written comments were received.

Pursuant to Section 16e, notwithstanding the receipt of comments (which, pursuant to Section 16d, ultimately must be summarized and responded to in a report for public distribution and publication in the New Jersey Register) the Commissioner may adopt these rules immediately upon the expiration of the public comment period by filing the notice of adoption with the Office of Administrative Law for publication in the New Jersey Register. These new rules shall be effective upon the date of filing with the Office of Administrative Law, October 15, 1993.

Summary of Public Comments and Agency Responses:
No public comments were received.

Summary of Agency-Initiated Changes:

At N.J.A.C. 11:21-14.4(d), the term "Risk-assuming" has been changed to "risk-assuming"; the capitalization was inappropriate.

At N.J.A.C. 11:21-14.5(b), the address for filing with the Department includes a minor change.

At N.J.A.C. 11:21-14.5(c)4, the "10" has been changed to "three", so that the statement accompanying an application for risk-assuming carrier status need only provide the carrier's group experience, if any, for the past three years, rather than 10. Initially, the 10 year period was intended to allow carriers who withdrew from the small employer market (for five years) an opportunity to reenter as a risk-assuming carrier applicant, presenting all New Jersey group experience, rather than national group experience. However, the Department has determined that in attempting to address the problem of a carrier wishing to reenter the market after an extended absence, the requirements for all carriers in this regard are unnecessarily cumbersome. The Department believes that, at this time, three years of data is sufficient for the Department to evaluate a carrier's expertise to participate as a risk-assuming carrier. This change reduces the burdens of compliance with these rules.

At N.J.A.C. 11:21-14.7(a)3, the language has been revised regarding capital and surplus requirements for insurers. The phrase "a carrier has made application for" has been added after "unless." The phrase "has been granted" is deleted, and the phrase "and such application has not been disapproved" has been added after "N.J.A.C. 11:2-39." This change has been made to more accurately reflect the nature of the application for a waiver under N.J.A.C. 11:2-39, and to better coordinate the waiver application process under N.J.A.C. 11:2-39 with the risk-assuming application process under these rules. Technically, applications for waiver have no specified time period for approval or deemed approval, and the application process can be extended for up to six months, while the risk-assuming election must be accepted or denied within 90 days of its receipt by the Commissioner. The change is a practical one especially in this initial election period. It is less onerous on carriers, some of whom otherwise would be unable to obtain risk-assuming status because they would be unable to obtain an affirmative waiver grant under N.J.A.C. 11:2-39 in a time period satisfactory for purposes of N.J.A.C. 11:21-14.

Similar conforming changes regarding the waiver applications have been made to Exhibit U, Part 3, in question 3 of Section D, set forth in the Appendix to the chapter.

Full text of the adopted new rules follows (additions to proposal indicated in boldface with asterisks ***thus***; deletions from proposal indicated in brackets with asterisks *[thus]*):

SUBCHAPTER 14. DECLARATION AND APPROVAL OF REINSURING OR RISK-ASSUMING CARRIER STATUS

11:21-14.1 Purpose and scope

This subchapter establishes the rules applicable to all carriers requesting to operate as a risk-assuming and reinsuring carrier under the Program, and sets forth the standards for approval of risk-assuming applications by the Commissioner.

11:21-14.2 Definitions

(a) Words and terms defined at N.J.S.A. 17B:27A-17 and N.J.A.C. 11:21-1.2, when used in this subchapter, shall have the meanings as defined by the Act or for the chapter, unless more specifically defined in (b) below or unless the context clearly indicates otherwise.

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

"Health maintenance organization" or "HMO" means a company operating in accordance with N.J.S.A. 26:2J-1 et seq.

"Health service corporation" is a company operating in accordance with N.J.S.A. 17:48E-1 et seq.

"Hospital service corporation" is a company operating in accordance with N.J.S.A. 17:48E-1 et seq.

"Insurer" means a company transacting the business of health insurance as defined at N.J.S.A. 17B:17-4.

"Medical service corporation" is a company operating in accordance with N.J.S.A. 17:48A-1 et seq.

"Reinsuring carrier" means a small employer carrier issuing small employer health benefits plans on a guaranteed issue basis that has elected pursuant to N.J.S.A. 17B:27A-34 and this subchapter to be eligible for reimbursement of losses it may incur under those small employer health benefits plans as well as to be responsible for payment of assessments for reimbursable losses incurred by other reinsuring carriers.

"Relief" means a deferral of obligation granted pursuant to N.J.S.A. 17B:27A-38 or a waiver of obligations granted in accordance with N.J.S.A. 17B:27A-26.

"Risk-assuming carrier" means a small employer carrier issuing small employer health benefits plans that has elected and been approved by the Commissioner pursuant to N.J.S.A. 17B:27A-34 and this subchapter to cover risks on a guaranteed issue basis without being subject to assessments for net reimbursable losses of the SEH Program incurred by reinsuring carriers which total the first four percent or less of the aggregate premiums from small employer health benefits plans issued by reinsuring carriers, and is not eligible for reimbursement of any losses it may incur under its small employer health benefits plans.

"Statutory election period" means the period of time specified at N.J.S.A. 17B:27A-35b for which an election to be a reinsuring carrier is binding. The initial "statutory election period" is that period in which carriers make their election on or before October 4, 1993, or within 30 days following the date that the Board submits its Plan of Operation to the Commissioner, whichever date is later, which election shall be effective for two years. The "statutory election period" which shall be binding for five years shall be applicable to any reinsuring carrier election made on or after October 5, 1993, or subsequent to the 30th day following the date that the Board submits its Plan of Operation to the Commissioner, whichever date is later.

11:21-14.3 General requirement

Each carrier, including each carrier among affiliated carriers, which is or becomes a small employer carrier, shall submit the information required by this subchapter independently from any other carrier. To the extent that any carrier's information is insufficient to meet the requirements of this subchapter, the carrier may submit the required information incorporating appropriate data from all of its affiliated carriers, if any, and so indicated on the form(s) submitted.

11:21-14.4 Declaration to be a reinsuring or risk-assuming carrier

(a) Every small employer carrier shall file a declaration with the Board and Commissioner on or before October 4, 1993 or within 30 days of the date that the Board files its Plan of Operation with the Commissioner for review, whichever date is later, stating whether the small employer carrier elects to operate as a risk-assuming carrier or a reinsuring carrier for purposes of compliance with the Program.

1. For purposes of compliance with this declaration deadline, the 30 day period shall begin to run from the date set forth on the notice sent to carriers by the Board of the submission of the Plan of Operation to the Commissioner, rather than the actual date of the Plan of Operation's submission, if the two dates are different.

2. The notice shall be considered properly sent if the Board sends it to the mailing address of the carrier which the carrier has on file with the Board.

3. Any small employer carrier that fails to file a timely declaration, or that is disapproved as a risk-assuming carrier, shall be deemed to have elected to operate as a reinsuring carrier.

(b) Every carrier that is not currently a small employer carrier but determines to become one, shall file, at least 90 days prior to issuing any small employer health benefits plans, a declaration with the Board and the Commissioner stating whether the carrier elects to operate as a risk-assuming carrier or as a reinsuring carrier for purposes of compliance with the Program. Any such carrier that fails to file a timely declaration, or that is disapproved as a risk-assuming carrier, shall be deemed to have elected to operate as a reinsuring carrier.

(c) A carrier operating as a reinsuring carrier which elects to operate as a risk-assuming carrier effective upon the expiration of the statutory election period applicable to the reinsuring carrier shall file a declaration with the Board and the Commissioner 90 days prior to the end of the applicable statutory election period stating that the reinsuring carrier elects to operate as a risk-assuming carrier for purposes of compliance with the Program.

1. The election shall not be effective until the end of the statutory election period.

2. The election shall not be effective until approved by the Commissioner as provided in this subchapter.

3. A reinsuring carrier that does not file such an election in a timely manner, or that is disapproved as a risk-assuming carrier, shall remain a reinsuring carrier through the end of the succeeding statutory election period, commencing upon the expiration date of the then-current statutory election period.

(d) Carriers electing to be reinsuring carriers shall complete the "Reinsuring Carrier Declaration" form set forth in Exhibit U, Part 1 of the Appendix to this chapter, incorporated herein by reference. Carriers electing to be *[Risk-assuming]* ***risk-assuming*** carriers shall complete the "Risk-Assuming Carrier Declaration" form set forth in Exhibit U, Part 2 of the Appendix to this chapter, incorporated herein by reference. Completed declaration forms shall be certified by the chief financial officer or other duly authorized officer of the carrier.

11:21-14.5 Application to be a risk-assuming carrier

(a) Every carrier filing a declaration electing to operate as a risk-assuming carrier additionally shall submit to the Commissioner an application to be a risk-assuming carrier as set forth below in (b), (c), (d) and (e).

(b) Carriers shall file five copies of the declaration and application with the Commissioner at the following address:

Attention: SEH Declaration/Approval
New Jersey Department of Insurance
[Division of Life/Health Actuarial Services]
Division of Financial Examinations
20 West State Street
CN-325
Trenton, New Jersey 08625-0325

(c) Every carrier filing for risk-assuming carrier status shall complete in full the Risk-Assuming Application Form set forth in Exhibit U, Part 3 of the Appendix to this chapter, incorporated herein by reference.

1. Carriers shall complete section D, E, or F of the Risk-Assuming Application Form, as is appropriate for the type of carrier.

2. The completed Risk-Assuming Application Form shall be certified by the chief financial officer, or other duly authorized officer, of the carrier.

3. The Risk-Assuming Application Form shall be supported by an actuarial opinion setting forth the assumptions and methodologies used to determine and certify that the carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2-27.

4. The Risk-Assuming Application Form shall be accompanied by a statement setting forth the carrier's group experience in New Jersey for the past *[10]* ***three*** years, if any. If a carrier or its affiliated carriers have no New Jersey group experience, then the statement shall set forth the national experience of the carrier and its affiliate(s). The experience information shall include:

i. The number of group contracts in force annually;

ii. The number of small employer group contracts in force annually;

iii. The lapse rate of all group contracts and small employer group contracts annually;

iv. The net earned premium for group contracts and small employer group contracts annually;

v. The incurred claims for group contracts and small employer group contracts annually;

vi. Assumptions used in developing the calculations in (c)4i through v above, where estimations have been made; and

vii. Assumptions regarding similarities and dissimilarities between the marketplace upon which the foregoing data is based and the current New Jersey small employer group market.

5. In completing and certifying the Risk-Assuming Declaration Form and the Risk Assuming Application Form, the carrier agrees that, upon approval by the Commissioner as a risk-assuming carrier:

i. It will not seek any reimbursement for any losses that will be incurred with respect to small employer health benefits plans as long as it retains its status as a risk-assuming carrier;

ii. It is financially competent to accept any obligation(s) required by the Act; and

iii. It does not intend to file an application for relief of any kind from its obligations under the Act for a period of one calendar year from the date that its application is approved or deemed approved.

(d) Carriers that have previously sought and obtained relief from their obligation(s) under the Act as a small employer carrier shall demonstrate to the satisfaction of the Commissioner that the carrier no longer has any need for relief and has been operating in full compliance with the Act, including the payment of all assessment amounts owed and issuance of small employer health benefits plans on a guaranteed issue basis, for a period of no less than 12 consecutive calendar months preceding the date of application.

(e) A declaration filed with the SEH Board to be a risk-assuming carrier shall not be effective until an application for risk-assuming carrier status has been approved as provided in this subchapter.

11:21-14.6 Procedures for review of applications for risk-assuming carrier status

(a) The time period for the Commissioner's review of an application for risk-assuming carrier status shall commence upon the day a complete application is received by the Commissioner.

(b) If the application is incomplete, the Department shall so advise the carrier in writing not later than 30 days after receipt of the application.

1. The application shall be deemed to be complete if the carrier is not notified in writing that the application is incomplete.

2. Notice to the carrier that the application is incomplete shall specify the missing item(s) or information. The notice shall advise the carrier that the deficiency must be cured within 30 days of receipt of notice, and that failure to cure the deficiency within 30 days of receipt of notice shall result in disapproval of the application. A deficiency shall not be considered cured until all of the missing items or information is received by the Department from the carrier.

3. Receipt of the specified missing items or information by the Department subsequent to the 30 day period specified in (b)2 above shall be deemed to be a new application and shall begin a new time period for review. Whenever a carrier submits information or missing items not specified by the Department in accordance with (b)2 above, it shall be deemed to be an amendment of the submission to which the information or missing items are to be attached, and shall begin a new time period for review.

(c) The Commissioner may approve an application for risk-assuming carrier status if the carrier meets the standards set forth in N.J.A.C. 11:21-14.7.

1. The Commissioner shall notify the carrier of the approval or any disapproval of its application in writing, and shall contemporaneously send a copy of the notice to the SEH Board.

2. Except as set forth in (b) above, an application shall be deemed approved if not disapproved within 90 days of its receipt.

3. Notice to the carrier that the application is disapproved shall be in writing and specify the reasons for disapproval.

11:21-14.7 Standards for approval

(a) The Commissioner may approve an application for risk-assuming status for a carrier that is an insurer if the carrier meets the following standards:

1. The carrier is authorized or admitted to transact the business of health insurance in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2-27 and as may be amended hereafter;

3. The carrier has at least the capital and surplus currently required to commence business in this State, unless ***a carrier has made application for*** a waiver of such requirements *[has been granted]* pursuant to P.L. 1993, c.235 and N.J.A.C. 11:2-39 ***and such application has not been disapproved***; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small employer group business.

(b) The Commissioner may approve an application for risk-assuming carrier status for health service corporations, hospital service corporations and medical service corporations if the carrier meets the following standards:

1. The carrier is authorized to transact business in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2-27 and as may be amended hereafter;

3. The carrier has either:

i. The surplus amounts required to be maintained in accordance with N.J.S.A. 17:48-10 or N.J.S.A. 17:48A-14, if the carrier is a hospital service corporation or a medical service corporation, respectively; or

ii. The amount required to be maintained in its special contingent surplus account for its other activities in accordance with N.J.S.A. 17:48E-17.1a and b, if the carrier is a health service corporation; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small group business.

(c) The Commissioner may approve an application for risk-assuming carrier status for HMOs if the carrier meets the following standards:

1. The carrier is authorized to transact business as an HMO in this State;

2. The carrier is not in a hazardous financial condition as set forth in N.J.A.C. 11:2-27 and as may be amended hereafter;

3. The carrier has a statutory net worth as filed annually with the Department of at least $1 million; and

4. The carrier is qualified based on its history of assuming and managing risk, and its experience in managing small group business.

(d) The Commissioner may solicit and consider comments from the Board in determining any carrier's application to operate as a risk-assuming carrier.

11:21-14.8 Hearings

(a) If the Commissioner disapproves an application for risk-assuming carrier status made pursuant to this subchapter, the carrier may request a hearing on the Commissioner's determination, but must do so within 20 days from the date of receipt of notice of such determination.

(b) A request for a hearing shall be in writing and shall include:

1. The name, address, and telephone number of a contact person representing the carrier who is familiar with the matter;

2. A copy of the notice of disapproval;

3. A statement requesting a hearing; and

4. A concise statement describing the basis for which the carrier believes that the Commissioner's findings of fact are erroneous.

(c) Upon receipt of a properly completed request for a hearing which sets forth good-faith, disputed issues of material fact, the Commissioner shall transmit the matter to the Office of Administrative Law for a hearing consistent with the Uniform Administrative Procedure Rules, N.J.A.C. 1:1.

APPENDIX

. . .

EXHBIIT U

PART 1

REINSURING CARRIER DECLARATION

(To be submitted to the SEH Program Board and the New Jersey Department of Insurance.)

Information on Person Completing this Declaration

Name: _____

Title: _____

Address: _____

_____

Phone: _____ FAX: _____

(Carrier Name) _____ elects to operate as a reinsuring carrier for purposes of complying with the Small Employer Health Benefits Program established pursuant to N.J.S.A. 17B:27A-17 et seq. In accordance with N.J.S.A. 17B:27A-35, this election shall be binding:

a. for two years from the effective date of this election, set forth below, if this election is made prior to October 5, 1993, or within 30 days of the date the SEH Board submitted its Plan of Operation to the Commissioner, whichever date is later, or

b. for five years from the effective date of this election, set forth below, if this election is made on or after October 5, 1993 or after the 30th day following the submission of the Plan of Operation by the SEH Board to the Commissioner, whichever date is later.

This election is to be effective on (Month/Day/Year) on behalf of the company(ies) named below only. (Attach additional pages as necessary, and included NAIC numbers, if any.)

1. _____

2. _____

3. _____

_____ _____

Date Signature

EXHBIIT U

PART 2

RISK-ASSUMING CARRIER DECLARATION

(To be submitted to the SEH Program Board and the New Jersey Department of Insurance.)

Name: _____

Title: _____

Address: _____

_____

Phone: _____ FAX: _____

(Carrier Name) _____ elects to operate as a risk-assuming carrier for purposes of complying with the Small Employer Health Benefits Program established pursuant to N.J.S.A. 17B:27A-17 et seq. Upon approval by the Commissioner of the application to be a risk-assuming carrier, or deemed approval, it is agreed that the following conditions shall be binding upon each company for which this election has been made:

a. The company shall not seek any reimbursement for any losses it may incur with respect to small employer health benefits plans as long as the company retains its status as a risk-assuming carrier.

b. The company is financially competent to accept any obligations required by N.J.S.A. 17B:27A-17 et seq. and the company shall not seek relief of any kind from its obligations pursuant to N.J.S.A. 17B:27A-17 et seq. for a period of no less than one calendar year from the date that its application is approved or deemed approved by the Commissioner.

This election is to be effective on (Month/Day/Year) on behalf of the company(ies) named below only. (Attach additional pages as necessary, and included NAIC numbers, if any.)

1. _____
2. _____
3. _____

_____ _____

Date Signature

EXHIBIT U

PART 3

RISK-ASSUMING CARRIER APPLICATION

(Submit to: SEH Declaration/Approval, NJ Department of Insurance, Division of *[Life/Health Actuarial Services]* ***Financial Examinations***, 20 West State Street, CN 325, Trenton, NJ 08625-0325.)

SECTION A (To be completed by all applicants)

1. Name and Title of Person Completing this Application:

   _____

   Address: _____

   Phone: _____ Fax: _____

2. Name and NAIC numbers, if any, of carrier(s) for which this application is being completed (include Group number; attach additional pages as necessary and place a checkmark here ____):

   a. _____

   b. _____

   c. _____

SECTION B (to be completed by all applicants)

1. Is the carrier currently a reinsuring carrier? Yes____ No____

   If yes, what was the date the statutory election period began?

   _____

2. Has the carrier sought relief from any obligations pursuant to N.J.S.A. 17B:27A-26 (waiver) or N.J.S.A. 17B:27A-38 (deferral)?

   Yes____ No____

   If yes, what was the date the last relief was granted?

3. Is an actuarial certification attached? Yes____ No____

4. Is an experience report attached setting forth the information required by N.J.A.C. 11:21-14?

   Yes____ No____ Nonapplicable____

   If yes, is the experience report based on New Jersey data?

   Yes____ No____

   If no, please indicate by two-letter postal code the states upon which the data submitted is based.

   _____

   _____

   _____

SECTION C (To be completed by all applicants)

Is any of the information contained in this application and/or attachments based upon data from one or more carriers other than the carrier(s) listed in Section A2 above?

Yes____ No____

If yes, please indicate the specific information based upon other carrier data.

____ a. Actuarial certification

____ b. Experience data

____ c. Other

_____

_____

_____

If yes, please indicate the carrier(s) and their NAIC numbers, if applicable, whose data has been included in the information submitted. (Attach additional pages if necessary, and place a checkmark here ____.)

_____

_____

_____

SECTION D (To be completed by insurers)

1. Is the carrier authorized or admitted to transact the business of health insurance in New Jersey?

   Yes____ No____

   If no, the date the carrier anticipates admittance or authorization: _____

2. Is the carrier in a hazardous financial condition as set forth in N.J.A.C. 11:2-27?

   Yes____ No____

3. Does the carrier have a least the capital and surplus currently required to commence business in New Jersey?

   Yes____ No____

   If no, has the carrier *[received]* ***applied for*** a waiver from this requirement *[by the Commissioner]* pursuant to P.L. 1993, c.235 and N.J.A.C. 11:2-39?

   Yes____ No____

   If yes, *[does the carrier have at least the capital and surplus required for the carrier to commence

business in accordance with]* ***has*** the waiver ***application*** *[granted]* ***been disapproved*** by the Commissioner?

Yes____ No____

SECTION E To be completed by health service, hospital service and medical service corporations)

1. Is the carrier authorized to transact business in New Jersey?

   Yes____ No____

   If no, the date the carrier anticipates authorization: _____

2. Is the carrier in a hazardous financial condition as set forth in N.J.A.C. 11:2-27?

   Yes____ No____

3. Does the carrier have:

   a. (Health service corporation) The amount required to be maintained in accordance with N.J.S.A. 17:48E-17.1a and b for its nongroup contracts?

      Yes____ No____

   b. (Hospital service corporation) The surplus amounts required to be maintained in accordance with N.J.S.A. 17:48-10?

      Yes____ No____

   c. (Medical service corporation) The surplus amounts required to be maintained in accordance with N.J.S.A. 17:48A-14?

      Yes____ No____

SECTION F (To be completed by HMOs)

1. Is the carrier authorized to transact business as an HMO in New Jersey?

   Yes____ No____

   If no, date the carrier anticipates it will be authorized: _____

2. Is the carrier in a hazardous financial condition as set forth in N.J.A.C. 11:2-27?

   Yes____ No____

3. Does the carrier have a statutory net worth as filed annually with the Department of at least $1,000,000?

   Yes____ No____

I certify that the information contained in this application and any and all attachments hereto are accurate and truthful to the best of my knowledge and ability.

Date _____ Signature _____

LABOR

(a)

DIVISION OF PROGRAMS

1994 Maximum Weekly Benefit Rates
1994 Taxable Wage Base Under the Unemployment Compensation Law
1994 Contribution Rate of Governmental Entities and Instrumentalities
1994 Base Week
1994 Alternative Earnings Test
Adopted Amendments: N.J.A.C. 12:15-1.3, 1.4, 1.5, 1.6 and 1.7

Proposed: September 7, 1993 at 25 N.J.R. 3922(a).
Adopted: October 19, 1993 by Raymond L. Bramucci, Commissioner, Department of Labor.
Filed: October 21, 1993 as R.1993 d.589, **without change.**

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e), 43:21-3(c), 43:21-4(e), 43:21-7(b)(3), 43:21-7.3(e), 43:21-19(t), 43:21-27, 43:21-40 and 43:21-41.

Effective Date: November 15, 1993.
Expiration Date: July 30, 1995.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

12:15-1.3 Maximum weekly benefit rates

(a) In accordance with the provisions of the Unemployment Compensation Law, the maximum weekly benefit rate for benefits under the Unemployment Compensation Law is hereby promulgated as being $347.00 per week.

(b) The maximum weekly benefit rate for State Plan benefits under the Temporary Disability Benefits Law is hereby promulgated as being $325.00 per week.

(c) These maximum benefits shall be effective for the calendar year 1994 on benefit years and periods of disability commencing on or after January 1, 1994.

12:15-1.4 Taxable wage base under the Unemployment Compensation Law

In accordance with the provisions of N.J.S.A. 43:21-7(b)(3), the "wages" of any individual with respect to any one employer for the purpose of contributions under the Unemployment Compensation Law shall include the first $17,200 during the calendar year 1994.

12:15-1.5 Contribution rate for governmental entities and instrumentalities

(a) In accordance with the provisions of N.J.S.A. 43:21-7.3(e), the contribution rate for all governmental entities and instrumentalities electing to pay contributions under the Unemployment Compensation Law is hereby promulgated as being four-tenths of one percent (0.4 percent) for the entire calendar year.

(b) This contribution rate shall be effective on taxable wages paid in the calendar year 1994.

12:15-1.6 Base week

In accordance with the provisions of N.J.S.A. 43:21-19(t), the base week amount is hereby promulgated as being $123.00 per week for benefit years and periods of disability commencing on or after January 1, 1994.

12:15-1.7 Alternative earnings test

In accordance with the provisions of N.J.S.A. 43:21-4(e) and 43:21-41, in those instances in which the individual has not established 20 base weeks, the alternative earning amount for establishing eligibility is hereby promulgated as being $7,400 for benefit years and periods of disability commencing on or after January 1, 1994.

(a)

DIVISION OF PROGRAMS

Offset of Unemployment Insurance Benefits by Retirement and Pension Income

Adopted Amendment: N.J.A.C. 12:17-11.2

Proposed: September 7, 1993 at 25 N.J.R. 3923(a).
Adopted: October 20, 1993 by Raymond L. Bramucci, Commissioner, Department of Labor.
Filed: October 21, 1993 as R.1993 d.590, **without change.**

Authority: N.J.S.A. 43:21-1 et seq., specifically 43:21-5a.

Effective Date: November 15, 1993.
Expiration Date: January 4, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

12:17-11.2 Amount of reduction

(a) For weeks of unemployment beginning on or after January 1, 1981, the amount of any such reduction shall be determined by taking into account contributions made by the individual for the pension, retirement or retired pay, annuity and other similar periodic payment. The following schedule will apply.

1.-2. (No change.)

3. No reduction in benefits shall be made if the pension, retirement or retired pay, annuity or other similar periodic payment received by the individual is from an Old Age Social Security pension to which the individual has made any contribution.

4. (No change in text.)

(b)

DIVISION OF WORKERS' COMPENSATION

1994 Maximum Workers' Compensation Benefit Rates

Adopted Amendment: N.J.A.C. 12:235-1.6

Proposed: September 7, 1993 at 25 N.J.R. 3925(a).
Adopted: October 19, 1993 by Raymond L. Bramucci, Commissioner, Department of Labor.
Filed: October 21, 1993 as R.1993 d.591, **without change.**

Authority: N.J.S.A. 34:1-5, 34:1-20, 34:1A-3(e) and 34:15-12a.

Effective Date: November 15, 1993.
Expiration Date: May 3, 1996.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

12:235-1.6 Maximum workers' compensation benefit rates

(a) In accordance with the provisions of N.J.S.A. 34:15-12(a), the maximum workers' compensation benefit rate for temporary disability, permanent total disability, permanent partial disability, and dependency is hereby promulgated as being $460.00 per week.

(b) This maximum compensation shall be effective as to injuries occurring in the calendar year 1994.

LAW AND PUBLIC SAFETY

(c)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF ACCOUNTANCY

Biennial Renewal Fee for Inactive or Retired Licensees

Adopted Amendment: N.J.A.C. 13:29-1.13

Proposed: April 19, 1993 at 25 N.J.R. 1665(b).
Adopted: August 16, 1993 by the State Board of Accountancy, Robert Cagnassola, President.
Filed: October 21, 1993 as R.1993 d.585, **without change.**

Authority: N.J.S.A. 45:2B-6(g) and 45:2B-17.

Effective Date: November 15, 1993.
Expiration Date: May 23, 1995.

Summary of Public Comments and Agency Responses:
No comments were received.

Full text of the adoption follows:

13:29-1.13 Fees

(a) Fees for original applications, examinations, reexaminations and renewals, for certified public accountants, public accountants, corporations, partnerships, professional corporations, and for certified public accountants' license by endorsement are as follows:

1.-10. (No change.)

11. Late renewal fee: $50.00;

12. Biennial renewal, retired or inactive licensees: $40.00.

(d)

DIVISION OF CONSUMER AFFAIRS STATE BOARD OF DENTISTRY

Fees

Adopted Amendment: N.J.A.C. 13:30-8.1

Proposed: September 7, 1993 at 25 N.J.R. 3927(a).
Adopted: October 13, 1993 by the State Board of Dentistry, Marvin Gross, President.
Filed: October 22, 1993 as R.1993 d.598, **without change.**

Authority: N.J.S.A. 45:6-3 and 45:1-3.2.

Effective Date: November 15, 1993.
Expiration Date: March 12, 1995.

The State Board of Dentistry afforded all interested parties an opportunity to comment on the proposed amendment to its fee schedule, N.J.A.C. 13:30-8.1, as proposed in the New Jersey Register on September 7, 1993 at 25 N.J.R. 3927(a). The official comment period ended on October 7, 1993. Announcements of the opportunity to respond to the Board were also forwarded to the Star Ledger, the Trenton Times, the Courier-Post, the Bergen Record, the New Jersey Dental Association, the New Jersey Hospital Association and to other interested parties.

A full record of this opportunity to be heard can be inspected by contacting the State Board of Dentistry, Post Office Box 45005, Newark, New Jersey 07101.

Summary of Public Comments and Agency Responses:

During the 30-day comment period, the Board received one letter in response to the proposed amendment to its fee schedule from Arthur Meisel, Esq., Jamieson, Moore, Peskin & Spicer, counsel for the New Jersey Dental Association ("Dental Association").

The Dental Association argues, for the reasons specifically outlined below, that the proposed regulation fixes charges at a level that will raise amounts in excess of those estimated to be required, contrary to N.J.S.A. 45:1-3.2.

1. **Proposed increases exceed the expected rise in Board expenses over the two-year period.** Pointing out that Board expenses "are expected to rise approximately 30 percent over the two-year period, the Association

states that application fee increases range from between 50 percent and 125 percent and biennial registration fee increases range from between 60 percent and 100 percent.

RESPONSE: During the past biennial renewal cycle, unexpected revenues were collected which did not necessitate a fee increase for fiscal years 1991 and 1992. Accordingly, the 60 percent increase in the biennial registration fee equates to an average 15 percent per annum increase over a four-year period. The increase in the application fee is based on a reevaluation of actual review costs. The increase brings the amount assessed to a level which actually covers the administrative processing and avoids passing on to all board licensees the cost of processing new applications for licensure. This matches revenue with associated costs.

2. **Projected receipts from many revenue categories are unstated;** that is, no revenues are projected from application fees, verification of licensure and duplicates of wall certificates and licenses.

RESPONSE: The commenter is incorrect. The collection of these revenue categories were included in the original revenue projections.

3. **The projected number of licensees is understated,** a discrepancy that represents an understatement in revenue of more than $44,000. Recent Board records disclose that there are 7,309 active dentist registrants and 2,618 hygienists, while the Division's revenue projections are based upon 7,200 and 2,050 active certificates.

RESPONSE: The commenter received incorrect information regarding the number of active dental hygienists. As of September 30, 1993 there were 7,306 active dentists and 2,089 active dental hygienists. The revenue projections are based upon 7,200 active dentists and 2,050 active dental hygienists. It is the Division's experience with past fee increases that an average of one to five percent of the board's population may be expected not to renew. Accordingly, the Board of Dentistry's estimated population for the coming biennial period is a conservative estimate based on the increase in the biennial registration fee coupled with the new requirements for continuing education.

4. **The budget does not contain projected interest income.** The budget should contain an additional sum of between $60,000 and $100,000 representing interest on gross revenues in excess of $2,000,000.

RESPONSE: There is no authority in the Board's statute or in the fiscal year 1993-94 Appropriations Act which permits interest income on deposited funds to accrue to the benefit of the Board.

5. **The integrity of the figures which have been carried over to this fiscal year is questionable.** In fiscal year 1991-1992, $327,000 was appropriated to the Board, presumably reflecting the Board's spending plan submitted to the Division of Budget and Accounting. In fiscal year 1992-1993, the appropriation more than doubled to $868,000, although Board activity does not appear to have doubled during this one year period.

RESPONSE: The fiscal year 1991-92 appropriation to the Board of $327,000 provided start-up monies for this operating period. In fiscal year 1991-92 the Board expended the total sum of $709,000 while in fiscal 1992-93 the Board expended $858,000.

The Association also argues that:

1. At the August 4, 1993 Board meeting, the Division afforded the Board approximately 10 minutes to develop a fee schedule and virtually no time was provided to review revenue projections.

RESPONSE: All board administrative needs are articulated through the executive directors of the professional and occupational boards. The executive director acts as the board's administrative officer and represents the board in stating all financial needs and specific concerns in order to develop the data necessary for financial projections. It is not possible to develop a budget without the executive director's ongoing input and careful review of all line item expenditures, a procedure which was followed in this case. The board's revenue projections and expenditure budgets are based upon historical information, current spending trends and projected needs. All board spending plans are regularly monitored and updated quarterly to ensure prudent and efficient financial management, in accordance with Offices of Management and Budget and Legislative Services policies and State Appropriations Act requirements.

2. The time available to make a formal written comment has been severely protracted and, under the circumstances, is unreasonable. Although on September 8, 1993 Association representatives requested an opportunity to review data upon which the projections were based, Division representatives were unable to schedule a meeting until September 30, 1993. Furthermore, the Association could not conduct an independent analysis of projected expenses because the Division did not produce work papers or other supporting documents at the September 30, 1993 meeting.

RESPONSE: Many of the supporting documents are confidential and cannot be released because they relate to both ongoing and prior case investigation. Similarly, it would be of no real benefit to release the working copy of the operational budget when it contains figures which are subject to frequent adjustment. Accordingly, at the September 30, 1993 meeting the Association was provided four years of actual and projected expenditure and revenue data, information which the Division believes is responsive to the Association's request.

For all of the reasons set forth above, the Dental Association urged the Board to refrain from adopting the proposed regulation or to amend it to reflect the receipt of both unprojected and underprojected revenues which will be available during the biennial registration period.

RESPONSE: On October 13, 1993, the Board voted unanimously to adopt the fee schedule for the reasons articulated above.

Full text of the adoption follows:

13:30-8.1 Fee schedules

(a) The application fees charged by the Board of Dentistry shall be the following:

1. Dentists	$125.00
2. Dental Hygienists	$75.00
3. Dental Hygienists—expanded duties supplement	$25.00
4. Registered Dental Assistants	$35.00

(b) The Biennial Registration fees charged by the Board of Dentistry shall be the following:

1. Dentists:	
i. Active registration	$160.00
ii. Inactive registration	$70.00
iii. Branch office	$40.00
2. Dental Hygienists:	
i. Active registration	$50.00
ii. Inactive registration	$20.00
iii. Branch office	$20.00
3. Registered Dental Assistants	
i. Active registration	$50.00

(c) (No change.)

(d) Other fees:

1.-2. (No change.)

3. Registration of dentists by reciprocity—application fee	$250.00
4. Registration of dental hygienists by credentials—application fee	$125.00
5. Verification of licensure	$25.00
6. Duplicate wall certificate	$50.00
7. Duplicate license	$50.00

(e) (No change.)

(a)

DIVISION OF CRIMINAL JUSTICE

Safe and Secure Communities Program

Adopted Concurrent New Rules: N.J.A.C. 13:79

Proposed: September 20, 1993 at 25 N.J.R. 4511(a).
Adopted: October 21, 1993 by Fred DeVesa, Attorney General.
Filed: October 22, 1993 as R.1993 d.596, **without change.**

Authority: N.J.S.A. 52:17B-169.

Effective Date: October 22, 1993.
Expiration Date: October 22, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

CHAPTER 79
SAFE AND SECURE COMMUNITIES PROGRAM

SUCHAPTER 1. PURPOSE, SCOPE, DEFINITIONS

13:79-1.1 Purpose

This chapter describes the grants available from the Safe Neighborhoods Services Fund pursuant to the Safe and Secure Communities Act and establishes guidelines for the receipt of program funds and procedures to ensure grantee accountability.

13:79-1.2 Scope

The rules contained in this chapter shall govern the award of law enforcement personnel grants and law enforcement equipment grants from the Safe Neighborhoods Services Fund pursuant to the Safe and Secure Communities Act.

13:79-1.3 Definitions

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

"Act" means the Safe and Secure Communities Act, P.L. 1993, c.220 (N.J.S.A. 52:17B-159 et seq.).

"Commissioner" means the Commissioner of the Department of Community Affairs.

"Director" means the Director of the Division of Criminal Justice.

"Eligible municipality" means a municipality, which has a police department or force, in which the number of violent and nonviolent crimes per police officer exceeds 70 percent of the Statewide average of municipalities with a municipal police department or force, as reported in the 1991 Uniform Crime Report published by the Division of State Police.

"Fringe benefits" means payments made by the employer for an employee's retirement, social security, health and dental insurance, workers compensation, and unemployment, disability and survivor's insurance.

"Fund" means the Safe Neighborhoods Services Fund.

"Law enforcement equipment" or "equipment" means that equipment required for the provision of law enforcement services including, but not limited to, police cars, computers and peripheral equipment, police radios and other communications gear, weapons and body armor.

"Law enforcement project" or "project" means a project employing police officers for which a grant is awarded pursuant to this program.

"Other law enforcement personnel" means non-police employees who enhance a project's law enforcement capacity by performing paperwork and related support services, thereby allowing police officers to devote more time to direct community policing duties.

"Program" means the "Safe and Secure Communities Program."

SUBCHAPTER 2. THE SAFE AND SECURE COMMUNITIES PROGRAM

13:79-2.1 Program objectives

(a) The Safe and Secure Communities Program is designed to provide assistance to municipalities for programs which accomplish the following objectives, as warranted by the needs of the community:

1. Policing in a community-oriented manner through an emphasis on the use of foot patrols, personal interaction between police officers and residents, and participation in community crime prevention programs;

2. Targeting law enforcement activities toward the specific needs of persons who live or work in a particular neighborhood, such as children, senior citizens, or merchants;

3. Encouraging resident involvement in activities that contribute to crime prevention, including citizen patrols, safe houses, neighborhood watch groups, and crime prevention educational programs;

4. Reducing the incidence of criminal behavior, such as drug trafficking or youth gang activity, that disrupts the normal functioning of a community;

5. Implementing the Violent Offenders Removal Program (VORP) to identify and expeditiously apprehend violent criminals who operate within a targeted area; and

6. Developing other innovative strategies which hold promise for preventing or reducing crime within a defined neighborhood or with respect to a particular demographic group within the municipality.

13:79-2.2 Fund use and limitations

(a) Of the monies deposited in the fund, 75 percent shall be available for approved law enforcement projects and 25 percent shall be available for the purchase of law enforcement equipment, exclusive of the allocation to the Attorney General to enable the Division of Criminal Justice to provide technical and operational assistance to grantees.

(b) No more than 50 percent of the total dollar amount of grants awarded from the fund shall be allocated to municipalities eligible to receive State aid pursuant to P.L. 1985, c.170 (N.J.S.A. 52:27D-118.11a, b, and c; Safe and Clean Neighborhood Fund).

(c) Notwithstanding any law or regulation to the contrary, a municipality may expend grant moneys in the local budget year in which they are received.

13:79-2.3 Notification and award of funds

(a) Program grants shall be awarded in two annual cycles.

1. Applicant municipalities with a fiscal year starting January 1 shall be notified of grant approval or denial no later than October 30. These grants shall be awarded on January 1.

2. Applicant municipalities with a fiscal year starting July 1 shall be notified of grant approval or denial no later than April 30. These grants shall be awarded on July 1.

13:79-2.4 Application for funds

All municipalities applying for funds for both law enforcement personnel grants and law enforcement equipment grants must submit separate proposals to the Division of Criminal Justice by the deadline dates specified in the program request for proposals available from the Division of Criminal Justice.

13:79-2.5 Application components for initial program grants

(a) Problem Statement: Applications for program grants shall include a narrative description of the need for grant funding and how the funding will be used to further the program objectives.

1. Law enforcement personnel grant application shall clearly describe the problem the project will address. In addition, law enforcement personnel grant applications shall:

i. Include such statistics as municipal arrest rates, reported crimes, juvenile offenses, and other data relevant to the project;

ii. Provide a brief description of current municipal efforts and activities that deal with crime that are being planned or implemented;

iii. Provide a brief synopsis of the ability of the municipal police department to implement the program, including information that describes the target area, defines whether a neighborhood or entire municipality is included in the project, specifies how the officers will be deployed, including their work schedules and hours and shifts that wil be affected, and outlines the policing strategies that will be employed; and

iv. Include indicators by which progress in achieving program objectives and the project's purpose will be measured.

2. Law enforcement equipment grant applications shall include information on the type, amount, and estimated cost of the equipment requested. The application shall also indicate how the equipment will be deployed, its benefit to the community, and any other relevant information.

(b) Objectives: Applications for program grants shall include objectives and an explanation of how the objectives will facilitate accomplishments consistent with program goals.

(c) Program description and activities: Applications for program grants shall provide examples of actual program activities, describing how police officers will be utilized and/or how equipment will enhance program activities.

(d) Program evaluation: Applications for program grants shall describe implementation of a system to collect information necessary to evaluate success in achieving program objectives.

(e) Applications for program grants shall also include any other information deemed necessary by the Division of Criminal Justice to effectively evaluate an application for funds.

13:79-2.6 Confidentiality

An application for a grant under this program and any supporting documentation are not public records for purposes of P.L. 1963, c.73 (N.J.S.A. 47:1A-1 et seq.). These documents are confidential and shall not be released except to law enforcement personnel in connection with their official duties.

SUBCHAPTER 3. PROGRAM GRANTS

13:79-3.1 Project grants

(a) An eligible municipality may apply to the Division of Criminal Justice for a grant from the fund to be used exclusively to pay the initial salaries of police officers and other law enforcement personnel deployed in a law enforcement project which is designed to meet the objectives of the program.

(b) A municipality which receives a grant for a law enforcement project shall be responsible for paying the fringe benefits of all police officers or other law enforcement personnel hired, which shall be deemed the local cash match. Requests for overtime funds will not be considered.

(c) A municipality shall agree, as a condition of a grant awarded pursuant to this Act, not to reduce its regular complement of police officers and other law enforcement personnel during any grant period.

(d) No municipality shall receive a grant exceeding $200,000 in any program year for an approved law enforcement project. If any funds remain after all approved projects and law enforcement equipment grants have been funded in any program year, funding in excess of the limitation may be awarded to selected grantees pursuant to the program selection criteria contained in N.J.A.C. 13:79-3.6.

13:79-3.2 Initial project grants

Initial grants for law enforcement projects shall be awarded only during the first two program years following the effective date of the Act.

13:79-3.3 Project continuation grants

(a) A municipality which receives an initial grant for a law enforcement project may request from the Division of Criminal Justice continuation funding in subsequent years to continue that project, subject to availability of funds. Such request shall include information which demonstrates that the project is effectively meeting the objectives of the program to justify continued funding.

(b) Approval of a continuation grant for a law enforcement project is contingent upon certification by the Attorney General that the project is effectively meeting the objectives of the program.

(c) A municipality that is eligible to receive an initial grant under the Act is eligible to receive continuation funding. An application for such funding shall be in a form prescribed by the Division of Criminal Justice.

13:79-3.4 Equipment grants

(a) Any municipality which has a police department or force may apply to the Division of Criminal Justice for a grant from the fund to be used exclusively to purchase law enforcement equipment.

(b) A municipality which receives a grant for the purchase of law enforcement equipment shall contribute a cash match of no less than 25 percent of the grant amount.

(c) No municipality shall receive a grant exceeding $50,000 in any program year for the purchase of law enforcement equipment. If any funds remain after all approved projects and law enforcement equipment grants have been funded in any program year, funding in excess of the limitation may be awarded to selected grantees pursuant to the program selection criteria contained in N.J.A.C. 13:79-3.6.

13:79-3.5 Initial equipment grants

Initial grants for the purchase of law enforcement equipment shall be awarded throughout the program, subject to availability of funds. Continuation funding is not available for the purchase of law enforcement equipment.

13:79-3.6 Selection criteria

(a) The Director shall evaluate and rank program grant applications on the basis of the municipality's realistic opportunity to achieve the specified objectives of the program.

(b) The Director shall give additional weight to applications which:

1. Propose cooperative policing agreements between two or more municipalities pursuant to P.L. 1973, c.208 (N.J.S.A. 40:8A-1 et seq.) or P.L. 1952, c.72 (N.J.S.A. 40:48B-1 et seq.);

2. Provide evidence of a project planning process which has involved residents of the proposed project areas and institutions and groups active in these areas;

3. Provide for the re-employment of police officers who have been laid off by the municipality for budgetary reasons prior to March 1, 1993;

4. Clearly delineate project outcome goals that are both time-lined and measurable;

5. Maximize the use of funding and resources other than those provided by the program;

6. Provide for the mobilization of residents as volunteer participants;

7. Where practicable, provide for the employment of related law enforcement personnel to perform paperwork and related support services in order to free up police officers for community policing duties; and

8. Provide for maximum program accountability.

13:79-3.7 Grant selection process

(a) The selection process for initial grants is as follows:

1. The Director, on or before September 1 and March 1 of each year, shall be provided with initial grant applications.

2. The Attorney General and the Commissioner shall announce the selection of initial grant recipients on or before October 30 and April 30 of each year.

(b) The selection process for project continuation grants is as follows:

1. The Director, on or before September 1 and March 1 of each year, shall forward to the Attorney General recommendations for the award of project continuation grants.

2. The Attorney General shall review requests for project continuation funding, the recommendations of the Director, and shall select as project continuation grant recipients those municipalities whose projects are effectively meeting the objectives of the program.

13:79-3.8 Reconsideration

Within 10 days after receipt of notification of grant denial, a municipality may submit additional grant application information to the Division of Criminal Justice and may request reconsideration of the grant application.

SUBCHAPTER 4. GRANTEE ACCOUNTABILITY

13:79-4.1 Certification

(a) A municipality selected as a grant recipient under this program shall certify that all grant funds shall be used exclusively for the purposes specified in the grant award.

(b) A municipality selected as a law enforcement personnel grant recipient shall certify that it shall not reduce its regular complement of police officers and other law enforcement personnel during any grant period.

13:79-4.2 Agreement prerequisites

(a) Prior to entering into an agreement with the Division of Criminal Justice to receive grant funds, a municipality selected as a grant recipient under this program shall provide:

1. An application authorization form signed by the mayor or other chief administrative or executive officer of the municipality and a

resolution by the municipal governing body authorizing the municipality to enter into an agreement with the Division of Criminal Justice for the funds;

2. For law enforcement personnel grant recipients, authorization by the governing body for the provision of fringe benefit expenses; and

3. For law enforcement equipment grant recipients, authorization by the governing body for the 25 percent cash match.

13:79-4.3 Reporting

(a) A municipality selected as a grant recipient under this program will be required to meet the Division of Criminal Justice programmatic and fiscal reporting standards, including:

1. Submission of quarterly narrative and statistical reports to the Division of Criminal Justice describing program activities and progress for the award period;

2. Submission of monthly fiscal reports to the Division of Criminal Justice;

3. Maintenance of a bookkeeping system, records, and separate grant files to account for all grant monies spent and all matching funds contributed to the program; and

4. Maintenance of a separate account for all grant monies and all matching funds contributed to the program.

SUBCHAPTER 5. ASSISTANCE FOR GRANTEES

13:79-5.1 Technical and operational assistance

(a) The Division of Criminal Justice shall provide technical and operational assistance to grantees, which shall include:

1. Assistance in implementing an effective community policing program, including training and development of operational plans, schedules, and strategies; and

2. Coordination of and assistance with violent offender removal programs (VORP).

TRANSPORTATION

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Speed Limits

Routes U.S. 40, U.S. 40 and U.S. 322, and N.J. 87 in Atlantic County

Adopted Amendments: N.J.A.C. 16:28-1.6, 1.56 and 1.111

Proposed: September 7, 1993 at 25 N.J.R. 3942(a).
Adopted: October 8, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: October 21, 1993 as R.1993 d.574, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-98.

Effective Date: November 15, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:28-1.6 Route U.S. 40[1]

(a) The rate of speed designated for the certain parts of State highway Route U.S. 40 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic:

i.-ii. (No change.)

iii. In Atlantic County;

(1) (No change.)

(2) Buena Vista Township:

(A)-(C) (No change.)

(D) Zone 4: 50 miles per hour between Holly Avenue and the Buena Vista Township-Hamilton Township line (approximate mileposts 38.62 to 39.15); thence

(3) Hamilton Township:

(A) Zone 1: 50 miles per hour between the Hamilton Township-Buena Vista Township line and 350 feet west of Essex Avenue (approximate mileposts 39.15 to 44.95); thence

(B) Zone 2: 45 miles per hour between 350 feet west of Essex Avenue and 500 feet east of Walkers Forge Road (approximate mileposts 44.95 to 45.63); thence

(C) Zone 3: 50 miles per hour between 500 feet east of Walkers Forge Road and 500 feet west of Route N.J. 50 (approximate mileposts 45.63 to 46.25); thence

(D) Zone 4: 40 miles per hour between 500 feet west of Route N.J. 50 and 200 feet west of Taylor Road (approximate mileposts 46.25 to 46.73); thence

(E) Zone 5: 30 miles per hour between 200 feet west of Taylor Road and County Road 617 Connector Road (approximate mileposts 46.73 to 47.29); thence

(F) Zone 6: 40 miles per hour between County Road 617 Connector Road and 400 feet east of Old Egg Harbor Road (approximate mileposts 47.29 to 47.48); thence

(G) Zone 7: 50 miles per hour between 400 feet east of Old Egg Harbor Road and the Route U.S. 322-Route U.S. 40 junction (approximate mileposts 47.48 to 51.71).

[1]See also N.J.A.C. 16:28-1.56 and 1.118

16:28-1.56 Route U.S. 40 and U.S. 322

(a) The rate of speed designated for the certain parts of State highway U.S. 40 and U.S. 322 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic:

i. In Atlantic County:

(1) Hamilton Township:

(A) Zone 8: 55 miles per hour between the Route U.S. 322-Route U.S. 40 Junction and the Egg Harbor Township-Hamilton Township Line (approximate mileposts 51.71 to 53.15); thence

Recodify existing (1)-(4) as (2)-(5) (No change in text.)

16:28-1.111 Route 87

(a) The rate of speed designated for the certain parts of State highway Route 87 described in this subsection shall be established and adopted as the maximum legal rate of speed:

1. For both directions of traffic in the Cities of Atlantic City and Brigantine, Atlantic County:

i. 45 miles per hour between Route U.S. 30 and the end of the New Jersey Department of Transportation jurisdiction (approximate mileposts 0.0 to 1.72.)

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping
Route N.J. 28 in Somerset County

Adopted Amendment: N.J.A.C. 16:28A-1.19

Proposed: September 7, 1993 at 25 N.J.R. 3943(a).
Adopted: October 8, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: October 21, 1993 as R.1993 d.575, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-198.

Effective Date: November 15, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:28A-1.19 Route 28

(a) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no stopping or standing" zones where stopping or standing is prohibited at all times except as provided in N.J.S.A. 39:4-139. In accordance with the provisions of N.J.S.A. 39:4-198, proper signs shall be erected.

1.-6. (No change.)

7. No stopping or standing in the Borough of Bound Brook, Somerset County:

i. Along the northerly (westbound) side (Union Avenue):

(1) Between the Borough of Middlesex-Borough of Bound Brook corporate line and a point 110 feet west of the prolongation of the westerly curb line of East Street;

(2) From the easterly curb line of Church Street to a point 86 feet easterly therefrom;

(3) From the westerly curb line of Church Street to a point 86 feet westerly therefrom;

(4) From the easterly curb line of Livingston Street to a point 85 feet easterly therefrom;

(5) From the westerly curb line of Livingston Street to a point 85 feet westerly therefrom;

(6) From a point 270 feet west of the westerly curb line of Thompson Avenue to the Borough of Bound Brook-Township of Bridgewater corporate line.

ii. Along the southerly (eastbound) side (Union Avenue):

(1) From the Township of Bridgewater-Borough of Bound Brook corporate line to a point 122 feet east of the easterly curb line of Thompson Avenue;

(2) From the westerly curb line of Vosseller Avenue to a point 282 feet westerly therefrom;

(3) From the westerly curb line of Livingston Street to a point 85 feet westerly therefrom;

(4) From the easterly curb line of Livingston Street to a point 85 feet easterly therefrom;

(5) From the westerly curb line of Church Street to a point 86 feet westerly therefrom;

(6) From the easterly curb line of Church Street to a point 86 feet easterly therefrom;

(7) From the easterly curb line of East Street to the Borough of Bound Brook-Borough of Middlesex corporate line.

8.-13. (No change.)

(b) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no parking bus stop" 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.-16. (No change.)

17. In the Borough of Bound Brook, Somerset County:

i. Along the eastbound (southerly) side (Union Avenue):

(1) Near side bus stops:

(A) Tea Street—Beginning at a point 35 feet from the westerly curb line of Tea Street and extending 70 feet westerly therefrom;

(B) Thompson Avenue—Beginning at a point 35 feet from the westerly curb line of Thompson Avenue and extending 70 feet westerly therefrom;

(C) Washington Street—Beginning at a point 35 feet west of the prolongation of the westerly curb line of Washington Street and extending 70 feet westerly therefrom;

(D) Windsor Street—Beginning at a point 35 feet from the westerly curb line of Windsor Street and extending 70 feet westerly therefrom;

(E) Mountain Avenue—Beginning at a point 35 feet from the westerly curb line of Mountain Avenue and extending 70 feet westerly therefrom.

(2) Far side bus stops:

(A) East Street—Beginning at a point 35 feet east of the easterly curb line of East Street and extending 65 feet easterly therefrom.

ii. Along the westbound (northerly) side (Union Avenue):

(1) Near side bus stops:

(A) Mountain Avenue—Beginning at a point 35 feet from the easterly curb line of Mountain Avenue and extending 70 feet easterly therefrom;

(B) Washington Street—Beginning at a point 35 feet from the easterly curb line of Washington Street and extending 70 feet easterly therefrom;

(C) Tea Street—Beginning at a point 35 feet east of the easterly curb line of Tea Street and extending 70 feet easterly therefrom.

(2) Far side bus stops:

(A) Windsor Street—Beginning at a point 35 feet west of the prolongation of the westerly curb line of Windsor Street and extending 70 feet westerly therefrom;

(B) Thompson Avenue—Beginning at a point 35 feet west of the westerly curb line of Thompson Avenue and extending 65 feet westerly therefrom.

(c)-(f) (No change.)

(g) The certain parts of State highway Route 28 described in this subsection shall be designated and established as "no parking during certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following "no parking during certain hours" zones:

1. (No change.)

2. In the Borough of Bound Brook, Somerset County:

i. Along the northerly (westbound) side (Union Avenue):

(1) Beginning at a point 105 feet west of the prolongation of the westerly curb line of Windsor Street to a point 225 feet westerly therefrom from 8:00 A.M. to 4:00 P.M. on school days.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID

BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS

Restricted Parking and Stopping Route N.J. 77 in Cumberland County

Adopted Amendment: N.J.A.C. 16:28A-1.41

Proposed: September 7, 1993 at 25 N.J.R. 3944(b).

Adopted: October 8, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: October 21, 1993 as R.1993 d.576, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1 and 39:4-199.

Effective Date: November 15, 1993.

Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:

No comments received.

Full text of the adoption follows:

16:28A-1.41 Route 77

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

(e) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "no parking certain hours" zones. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following zones:

1. No parking certain hours in Cumberland County:

i. In the City of Bridgeton:

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

(3) Along the southbound (west side) for street cleaning from 2:00 A.M. to 6:00 A.M. Monday through Saturday:

(A) Beginning at a point 108.57 feet south of the southerly curb line of Washington Street to a point 305.57 feet south of the southerly curb line of Washington Street.

(B) Beginning at a point 40.70 feet south of the southerly curb line of Church Lane to a point 115.70 feet south of the southerly curb line of Church Lane.

(C) Beginning at a point 142.95 feet south of the southerly curb line of East Commerce Street to a point 309.95 feet south of the southerly curb line of East Commerce Street.

(4) Along the northbound (east side) for street cleaning from 2:00 A.M. to 6:00 A.M. Monday through Saturday:

(A) Beginning at a point 105.00 feet north of the northerly curb line of Route N.J. 49 to a point 180.00 feet north of the northerly curb line of Route N.J. 49.

(B) Beginning at a point 35.77 feet south of the southerly curb line of McCormick Place to a point 108.77 feet south of the southerly curb line of McCormick Place.

(C) Beginning at a point 90.00 feet north of the northerly curb line of McCormick Place to a point 164.40 feet north of the northerly curb line of McCormick Place.

(D) Beginning at a point 100.00 feet north of the northerly curb line of East Commerce Street to a point 167.00 feet north of the northerly curb line of East Commerce Street.

(E) Beginning at a point 261.00 feet north of the northerly curb line of East Commerce Street to a point 444.00 feet north of the northerly curb line of East Commerce Street.

(f) (No change.)

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Restricted Parking and Stopping
Route N.J. 77 in Cumberland County
Adopted Amendment: N.J.A.C. 16:28A-1.41

Proposed: June 21, 1993 at 25 N.J.R. 2649(a); see also 25 N.J.R. 3944(a), September 7, 1993.

Adopted: October 8, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: October 21, 1993 as R.1993 d.577, **with a technical change** not requiring additional public notice and comment (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 27:1A-5, 27:1A-6, 39:4-138.1, 39:4-197.5, 39:4-198 and 39:4-199.

Effective Date: November 15, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

On June 21, 1993, the Department of Transportation (Department) promulgated proposed amendments concerning restricted parking and stopping along the following Routes: N.J. 7 in Essex County; U.S. 9 in Atlantic County; N.J. 47 in Cumberland County; N.J. 77 in Cumberland County; N.J. 173 in Hunterdon County; and U.S. 206 in Mercer County. Said notice appeared in the New Jersey Register at 25 N.J.R. 2649(a).

The Department's staff in its review of the proposed amendments discovered an error in the text of the proposed amendment to N.J.A.C. 16:28A-1.41, concerning time limit parking on Route N.J. 77 in the City of Bridgeton, Cumberland County. The Notice of Proposal filed with the Office of Administrative Law (see PRN 1993-327) reflected that in N.J.A.C. 16:28A-1.41(f)1ii(1)(B) as read "Beginning at a point 124.95 feet" should have read "Beginning at a point **142.95** feet . . ." The figures were transposed. The Department, determining that the distance was significant, extended the comment period specific to that portion being in error, to October 7, 1993, to afford any interested person an opportunity to discern from the proposal where the restricted space proposed by the Department began. Said notice of correction and extension of comment period appeared at 25 N.J.R. 3944(a).

On July 26, 1993, the Department adopted amendments of all the proposed restrictions effective September 7, 1993, except N.J.A.C. 16:28A-1.41(f)1ii(1)(B) pertaining to Route N.J. 77 in the City of Bridgeton, Cumberland County. Said notice appeared at 25 N.J.R. 4118(a).

The Department therefore adopts N.J.A.C. 16:28A-1.41(f)1ii(1)(B) concerning time limit parking on Route N.J. 77 in the City of Bridgeton, Cumberland County.

Full text of the adoption follows (deletions indicated in brackets with asterisks *[thus]*):

16:28A-1.41 Route 77

(a)-(e) (No change.)

(f) The certain parts of State highway Route 77 described in this subsection shall be designated and established as "Time Limit Parking" zones where parking is prohibited at all times except as specified below in this subsection. In accordance with the provisions of N.J.S.A. 39:4-199, permission is granted to erect appropriate signs at the following time limit zones:

1. In the City of Bridgeton, Cumberland County:

i. (No change.)

ii. Fifteen minutes time limit parking from 6:00 A.M. to 9:00 P.M. Monday through Saturday.

(1) Along the southbound (west) side:

(A) (No change.)

(b) *[(Reserved)]* Beginning at a point 142.95 feet south of the southerly curb line of East Commerce Street and extending 22.00 feet south therefrom.

(c) (No change.)

(2) (No change.)

(b)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Weight Limits
Route U.S. 9 in Middlesex County
Adopted Concurrent New Rule: N.J.A.C. 16:30-6.1

Proposed: August 16, 1993 at 25 N.J.R. 3863(a).

Adopted: September 27, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.

Filed: October 21, 1993 as R.1993 d.578, **without change.**

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-75.

Effective Date: November 15, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:30-6.1 Route U.S. 9

For the protection and use of the Edison Bridge along Route U.S. 9 over the Raritan River in Sayreville Borough and the Township of Woodbridge, Middlesex County, there is established a weight limit of four tons registered gross weight. The right hand lane in both directions (mileposts 131.8 and 132.75) shall have a four ton gross weight limit. Trucks over four tons shall be restricted to using the left lane only on the Edison Bridge.

(a)

DIVISION OF TRAFFIC ENGINEERING AND LOCAL AID
BUREAU OF TRAFFIC ENGINEERING AND SAFETY PROGRAMS
Mid-Block Crosswalk
Route N.J. 71 in Monmouth County
Adopted New Rule: N.J.A.C. 16:30-10.16

Proposed: August 16, 1993 at 25 N.J.R. 3683(a).
Adopted: October 20, 1993 by Richard C. Dube, Director, Division of Traffic Engineering and Local Aid.
Filed: October 21, 1993 as R.1993 d.579, **without change**.

Authority: N.J.S.A. 27:1A-5, 27:1A-6 and 39:4-34.

Effective Date: November 15, 1993.
Expiration Date: May 7, 1998.

Summary of Public Comments and Agency Responses:
No comments received.

Full text of the adoption follows:

16:30-10.16 Route 71
(a) The certain parts of State highway Route 71 described in this subsection shall be designated as a mid-block crosswalk:
1. In Monmouth County:
i. Borough of Belmar:
(1) From a point 200 feet west of the westerly curb line of Belmar Plaza to a point six feet westerly therefrom.

OTHER AGENCIES

(b)

CASINO CONTROL COMMISSION
Applications
Vendor Registration Form
Junket Enterprise Registration Form
Adopted New Rules: N.J.A.C. 19:41-5.11 and 5.12
Adopted Amendment: N.J.A.C. 19:41-5.1

Proposed: September 7, 1993 at 25 N.J.R. 3951(a).
Adopted: October 20, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: October 21, 1993 as R.1993 d.571, **without change.**

Authority: N.J.S.A. 5:12-63c, 69a, 70a, 102 and 104b.

Effective Date: November 15, 1993.
Operative Date: December 20, 1993.
Expiration Date: April 15, 1995.

Summary of Public Comments and Agency Responses:
Comments were received from the Sands Hotel & Casino ("the Sands") and the Division of Gaming Enforcement ("the Division").

COMMENT: Both the Sands and the Division stated their support for the proposed codification of the Vendor Registration Form and Junket Enterprise Registration Form. The Division noted that the new rules accurately reflect the recent review and revision of forms by a joint Commission-Division committee.

RESPONSE: The Commission concurs, as evidenced by the adoption herein.

Full text of the adoption follows:

19:41-5.1 Definitions
The following words and terms shall have the following meanings when used in this subchapter, unless the context clearly indicates otherwise.
...
"Hub facility" is defined at N.J.A.C. 19:55-1.1.
...

19:41-5.11 Vendor Registration Form
(a) A Vendor Registration Form (VRF) shall be in a format prescribed by the Commission and may require the following information regarding the enterprise:
1. Any official or trade name used;
2. Business address;
3. Telephone number;
4. The nature of the business and the type of goods or services being provided to the casino industry or hub facility;
5. Federal Employer Identification Number;
6. State and date of incorporation;
7. Whether the enterprise is minority- or women-owned and controlled and the enterprise certification number, if any, which information is voluntarily provided;
8. Form of business;
9. The date on which a formal offer and acceptance of the agreement to conduct business with a casino licensee or applicant or hub facility occurred;
10. Names and addresses of all subsidiaries;
11. The name, address and percentage of ownership of each entity directly owning more than five percent of the enterprise;
12. The names of each of the following:
i. Any individual who entered into the agreement with or will deal directly with the casino licensee or applicant or hub facility, including sales representatives; the immediate supervisors of such persons; and all persons responsible for the office out of which such supervisors work;
ii. Any officer, partner, or director who will be significantly involved in the conduct of the enterprise's business with the casino licensee or applicant or hub facility;
iii. If the enterprise is a sole proprietorship, the name of the sole proprietor; and
iv. Each beneficial owner of more than five percent of the outstanding voting securities of the enterprise, and the percentage of ownership; and
13. The name and position or title of the individual who supplied the information in the VRF.
(b) In addition to the information in (a) above, a completed VRF may include the following:
1. A certification of truth, which shall be dated and signed by an authorized agent of the casino licensee or applicant or hub facility, and which shall indicate such person's position or title and the casino licensee or applicant or hub facility submitting the form; and
2. A Principal Employee Data Summary Form for each individual in (a)12i through iv above, which may include the following information:
i. Name;
ii. Residence;
iii. Date of birth;
iv. Sex and race, which information is voluntarily provided;
v. Position with the enterprise; and
vi. Any gaming licenses or registrations currently held or pending in the State.

19:41-5.12 Junket Enterprise Registration Form
(a) A Junket Enterprise Registration Form (JERF) shall be in a format prescribed by the Commission and may require the junket enterprise to provide the following information:
1. Any official or trade name used;
2. Business address;
3. Telephone number;
4. Federal Employer Identification Number;
5. State and date of incorporation;
6. Whether the enterprise is minority- or women-owned and controlled and the enterprise certification number, if any, which information is voluntarily provided;
7. Form of business;
8. Names and addresses of all subsidiaries;

9. The name, address and percentage of ownership of each entity directly owning more than five percent of the enterprise;

10. The names of each of the following:

i. Any individual who entered into the agreement with the casino licensee or applicant and any individual who will deal directly with the casino licensee or applicant, including junket representatives; the immediate supervisors of such persons; and all persons responsible for the office out of which such supervisors work;

ii. Any officer, partner, or director who will be significantly involved in the conduct of the enterprise's business with the casino licensee or applicant;

iii. If the enterprise is a sole proprietorship, the name of the sole proprietor; and

iv. Each beneficial owner of more than five percent of the outstanding voting securities of the enterprise, and the percentage of ownership;

11. The name, date of birth, address and telephone number of any junket representative employed by the enterprise who is utilized in the conduct of junket activity but who is not listed in (a)10i above.

(b) In addition to the information in (a) above, a completed JERF may include the following:

1. A certification of truth, which shall be dated and signed by an officer or owner of the junket enterprise and shall indicate such person's position or title;

2. A Principal Employee Data Summary Form for each individual in (a)10i through iv above, which may include the following information:

i. Name;

ii. Residence;

iii. Date of birth;

iv. Sex and race, which information is voluntarily provided;

v. Position with the enterprise; and

vi. Any gaming licenses or registrations currently held or pending in the State; and

3. A Junket Enterprise Transmittal Form, which may include the following:

i. The anticipated date of arrival for the first junket involving the junket enterprise; and

ii. A certification of truth, which shall be dated and signed by an authorized agent of the casino licensee or applicant, and shall indicate such person's position or title.

(a)

CASINO CONTROL COMMISSION

Applications
Hearings
Reapplication by Natural Person After Denial or Revocation Motions for Reconsideration; Motions for Relief

Adopted Amendment: N.J.A.C. 19:41-8.8
Adopted New Rules: N.J.A.C. 19:42-2.2

Proposed: August 16, 1993 at 25 N.J.R. 3685(b).

Adopted: October 20, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.

Filed: October 21, 1993, as R.1993 d.572, **without change.**

Authority: N.J.S.A. 5:12-63c, 69a, 70a and d, 94 and 107d.

Effective Date: November 15, 1993.

Expiration Date: N.J.A.C. 19:41, April 15, 1995
N.J.A.C. 19:42, August 15, 1995.

Summary of Public Comments and Agency Responses:

Comments were received from the Division of Gaming Enforcement (Division). No other comments were received.

COMMENT: The Division suggested modifications to the proposed amendments to N.J.A.C. 19:41-8.8(d)3. The Division's position is that the consideration of factors which would support the application of waiver in a case in which waiver would be appropriate, that is, a registrant who has been disqualified pursuant to section 86c and who is seeking reapplication and is unable to meet the higher standard of rehabilitation, is inappropriate because waiver is a remedy to be utilized in limited circumstances, not a broad standard but a form of relief to be applied at the discretion of the Commission. The Department suggests the removal of the reference to waiver as one of the standards and the insertion of a finding of good character, honesty and integrity as the replacement standard. The Division also suggests that, in N.J.A.C. 19:41-8.8(a)3, the language "eligibility for reapplication shall be determined as specified in the agreement and not by the provisions of this section" may create an impression that an individual need only wait a specified time period to be eligible to reapply.

RESPONSE: The idea that the discretionary nature of the relief requires an undefinable standard is inconsistent with basic legal principles which require fairness and notice. The Commission, in *State v. Galanti,* Docket No. 90-0892-RC (Commission decision February 3, 1992), established guidelines for the application of waiver. It is only appropriate that the actual guidelines that would be utilized in the application of waiver at a contested case hearing in which a registrant had a section 86 disqualification would be considered as one of the possible standards in determining whether a motion to reapply is granted. Eliminating waiver as a standard and inserting good character, honesty and integrity would be redundant and leave a whole category of candidates for reapplication without a discernible standard for the consideration of their reapplication motion.

The Division also suggests that, in N.J.A.C. 19:41-8.8(a)3, the language "eligibility for reapplication shall be determined as specified in the agreement and not by the provisions of this section" may create an impression that an individual need only wait a specified time period to be eligible to reapply. The words "reapplication shall be determined as specified in the agreement" plainly allows the agreement negotiated between the parties to control. Such an agreement by its very nature requires specific terms for any reapplication. The proposed language, which is necessary in order to allow the full development of the settlement process in contested cases, has a plain meaning and is effective.

Full text of the adoption follows:

19:41-8.8 Reapplication by natural person after denial or revocation

(a) Any natural person whose licensure, registration, qualification or approval is denied or revoked by the Commission for failure to satisfy the affirmative qualification criteria of the Act or due to a Commission finding that such person is disqualified pursuant to section 86 of the Act, or both, may not, except as otherwise provided by this section, reapply for licensure, registration, qualification or approval until five years have elapsed from the date of denial or revocation. Notwithstanding the foregoing:

1. If the denial or revocation was based upon conviction of a disqualifying offense pursuant to section 86c of the Act and reapplication is to be evaluated under the standards of section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of conviction;

2. If the denial or revocation was based on acts constituting a section 86c disqualifying offense pursuant to section 86g and reapplication is to be evaluated under the standards of section 89 of the Act, reapplication is permitted after the lapse of 10 years from the date of the conduct in question; and

3. If the Commission approves an agreement resolving an application for or a complaint seeking the revocation of licensure, registration, qualification or approval which results in denial or revocation but permits reapplication after a stated period of less than five years, eligibility for reapplication shall be determined as specified in the agreement and not by the provisions of this section.

(b) Any natural person whose licensure, registration, qualification or approval is denied or revoked by the Commission on the basis of any of the statutory or regulatory provisions specified in (b)1 through 6 below may reapply for licensure, registration, qualification or approval upon satisfaction of the relevant requirements stated below. If the denial or revocation was based upon two or more statutory or regulatory provisions, the Commission shall permit reapplication only upon compliance with the requirements of this subsection as to each such provision. Any person seeking to reapply pursuant to this subsection shall file a certified petition stating with particularity the satisfaction of the specified requirements.

1. Lack of financial stability pursuant to sections 89b(1) or 90b of the Act: Reapplication is permitted upon said person achieving status of financial stability.

2. Lack of business ability and casino experience pursuant to sections 89b(3) or 90b of the Act: Reapplication is permitted upon said person acquiring the requisite business ability and casino experience.

3. Failure to satisfy residency requirement pursuant to sections 89b(4) or 90b of the Act: Reapplication is permitted upon said person actually establishing residency as required, or upon a Commission finding that such residency will be obtained prior to the completion of the processing of said reapplication, or upon a Commission finding that the residency requirements should be waived pursuant to sections 89b(4) or 90c of the Act.

4. (No change.)

5. Pending charges for a section 86c disqualifying offense pursuant to section 86d of the Act: Reapplication is permitted upon the disposition of pending charges.

6. Any statutory or regulatory provision which is subsequently repealed or modified: Reapplication is permitted upon a showing that the subsequent repeal or modification of the statutory or regulatory provision obviates the grounds for denial or revocation and justifies the conclusion that the prior decision should no longer bar reapplication.

(c) This regulation applies with equal force and effect to the denial or revocation of any application by a natural person for licensure, registration, qualification or approval, and to any denial or revocation of any reapplication for licensure, registration, qualification or approval which was filed after compliance with this section.

(d) Any natural person who is barred from reapplication for five years by (a) above may request permission to reapply at an earlier date by filing a petition in accordance with this subsection.

1. A petition for early reapplication may be filed at any time after one year has elapsed since the date of denial or revocation or at such earlier date as the Commission may specify in its order; provided, however, that no person shall, within the five-year period of restriction, file more than one such petition for each type of license, registration, qualification or approval authorized by the Act or regulations.

2. Such petition shall be certified and shall include written argument for the relief sought. The petition shall state with particularity the grounds upon which denial or revocation was based, and significant facts and circumstances arising since the denial or revocation which warrant early reapplication.

3. Upon receipt of such petition, the Commission shall offer the Division an opportunity to state its position in writing. Based upon the petition and any written submission from the Division, the Commission may deny the petition or, if it finds that the facts and circumstances presented are reasonably likely to result in licensure, registration, qualification or approval if considered in a plenary hearing, grant the petition. Factors that may be considered by the Commission may include, where appropriate, evidence which would support:

i. A finding of rehabilitation pursuant to sections 90h and 91d; or

ii. A waiver of disqualification pursuant to section 91e of the Act.

19:42-2.2 Motions for reconsideration; motions to reopen the record; motions for relief

(a) Any party may, within 10 days after the service of a final Commission order, file a motion for reconsideration which motion may seek to reopen the record. The motion shall be in writing and shall state the grounds upon which relief is sought. The Commission may grant such motion, under such terms and conditions as the Commission may deem appropriate, when the Commission finds just cause for reconsideration of the order based upon legal, policy or factual argument advanced by the movant or raised by the Commission on its own motion.

(b) Any party may, within one year after the service of a final Commission order, file a motion to reopen the record based upon newly discovered evidence. The motion shall be supported by an affidavit of the moving party or counsel showing with particularity the materiality and necessity of the additional evidence and the reason why such evidence was not presented at the original hearing or on a motion for reconsideration pursuant to (a) above. The Commission may grant such motion upon a showing that the newly discovered evidence is material and necessary, that sufficient reason existed for failure to present such evidence and that the evidence is reasonably likely to change the final decision of the Commission. Upon reconsideration, the Commission may modify its decision and order as the additional evidence may warrant.

(c) Any party may, within one year of the service of a final Commission order, file a motion for relief from such an order. The motion shall be in writing and shall state the grounds upon which relief is sought. The Commission may grant such motion and vacate or modify the order, reopen the record, or grant a hearing pursuant to N.J.S.A. 5:12-107, upon a showing of the following:

1. Mistake, inadvertence, surprise or excusable neglect;

2. Fraud, misrepresentation or other misconduct of an adverse party; or

3. Any other reason consistent with the public policy of the Act and in the interest of justice.

(d) No motion filed pursuant to this section, and no order granting such motion, shall suspend the operation of any final Commission order unless otherwise specified by order of the Commission.

(a)

CASINO CONTROL COMMISSION

Equal Employment and Business Opportunity Provisional Certification of Women and Minority Businesses; Ineligibility of Successor Businesses

Adopted Amendments: N.J.A.C. 19:53-1.2 and 5.4

Proposed: September 7, 1993 at 25 N.J.R. 3955(a).
Adopted: October 20, 1993 by the Casino Control Commission, Steven P. Perskie, Chairman.
Filed: October 21, 1993 as R.1993 d.573, **without change.**

Authority: N.J.S.A. 5:12-63, 69, 75, 134 and 135.

Effective Date: November 15, 1993.
Expiration Date: December 15, 1995.

Summary of Public Comments and Agency Responses:

COMMENT: The Sands Hotel and Casino commented that it did not object to the adoption of the proposed amendments.

RESPONSE: Accepted.

COMMENT: The Division of Gaming Enforcement (Division) submitted a comment indicating its general support for the proposed amendments but suggested that the amendments be modified to "be made consistent with the regulatory definitions, terms, and other relevant text as established by the Department of Commerce and Economic Development."

RESPONSE: Since the comment of the Division did not identify the manner in which it believes the proposed amendments are inconsistent with the rules of the Department of Commerce and Economic Development (DCED), the Commission is unable to provide a detailed analysis of or response to the comment. The Commission believes, however, that its rules are consistent the relevant provisions of the rules of DCED and, therefore, this part of the Division's comment is rejected.

Full text of the adoption follows:

19:53-1.2 Definitions

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

. . .

"Successor business" means a business enterprise which satisfies the definition of MBE or WBE set forth in N.J.A.C. 19:53-5.4 but, within the past two years, either was acquired as an ongoing business

or more than 50 percent of the assets of the business, as valued in accordance with generally accepted accounting principles, were acquired, other than by inheritance, from a person or persons in whose ownership or control the business enterprise would not qualify as an MBE or WBE.

...

19:53-5.4 Provisional certification of minority and women businesses

(a) An enterprise may qualify for provisional certification as an MBE, a WBE, or both. A successor business is not eligible for provisional certification as an MBE or WBE pursuant to this section but may apply for DCED certification as an MBE or WBE by complying with the requirements of N.J.A.C. 12A:11.

(b)-(j) (No change.)

PUBLIC NOTICES

EDUCATION

(a)

DIVISION OF POLICY AND PLANNING

Notice of Availability of Federal and State Grant Funds

1993-94 Edition of the Directory of Federal and State Programs

Take notice that the New Jersey Department of Education has available for the general public the 1993-94 edition of the Directory of Federal and State Programs which gives information regarding the availability of the Federal and State grant funds pursuant to N.J.S.A. 52:14-34.5. A copy of this directory has been given to each Local Education Agency and County Office of Education. Copies may be obtained by writing to:

Bureau of Budget, Accounting and Contracts
N.J. State Department of Education
CN 500
Trenton, NJ 08625-0500

Please note: This public notice is in accordance with N.J.S.A. 52:14-34.5 which requires... "State agencies that award Federal and State grant funds to publish a semi-annual notice regarding the availability of those funds in the New Jersey Register or an appropriate publication of the department..."

(b)

DIVISION OF POLICY AND PLANNING

Notice of Conditional Approval of the State Plan for Special Education

Take notice that the New Jersey Department of Education has received continued conditional approval of the State Plan for Special Education under Part B of the Individuals with Disabilities Education Act for fiscal years 1992 through 1994 by the Federal Office of Special Education and by the Federal Office of Special Education and Rehabilitative Services (OSERS). Approval of the Plan entitles New Jersey to receive an IDEA-B grant award of $74.9 million for fiscal year 1993-94. Eligible agencies receive notice of grant application procedures through the Department of Education.

Copies of the approved 1992-1994 State Plan are available to interested parties through the Office of Special Education, N.J. State Department of Education, CN 500, Trenton, NJ 08625-0500.

For further information regarding the State Plan contact Ms. Carol Kaufman at (609) 292-7605.

ENVIRONMENTAL PROTECTION AND ENERGY

(c)

DIVISION OF PARKS AND FORESTRY

Notice of Public Hearing
Proposed Exchange of Properties
Comprising Part of Delaware and Raritan Canal State Park

Take notice that the State of New Jersey, Department of Environmental Protection and Energy by the Division of Parks and Forestry, will hold a public hearing to seek comments on the proposed exchange of the following State-owned Delaware and Raritan Canal State Park lands no longer required for park purposes for certain lands owned by the City of Trenton which are adjacent to the D and R Canal State Park and will become a part of that facility.

Property Description

Lands of the Department of Environmental Protection and Energy

All that certain land at Delaware & Raritan Canal State Park containing approximately 1.14 acres designated as Block 148A, Lot 53 on the current Tax Map of the city of Trenton, county of Mercer, State of New Jersey and whose street address is 651 South Broad Street. These lands have been declared surplus to the needs of the Division of Parks and Forestry and are to be exchanged for lands owned by the City of Trenton. The City will also pay any difference in appraised value to the State, for the purchase of other park lands. The appraised value will be determined and certified by the Green Acres office prior to the exchange of the subject properties.

These lands are currently leased for commercial purposes and those commercial uses will continue after the sale.

Lands of the City of Trenton

All of those certain lands in the City of Trenton designated as Block 19E, Lots 75 and 95 and Block 19F, Lots 226 and 227 containing .5 acres more or less and whose street address is 227 and 230 North Hermitage Avenue.

The parcel maps and environment and economic assessment reports will be **available for review** Monday through Friday between the hours of 9:00 A.M. to 4:00 P.M. at the Division of Parks and Forestry's office located on 501 East State Street, Trenton, New Jersey, beginning on December 6, 1993.

These lands are currently vacant and will be used for park purposes after acquisition.

The proposed exchange of these State-owned lands will provide additional parkland within the Delaware and Raritan Canal State Park.

The **public hearing** will be held on:

Monday, December 20, 1993 at 10:00 A.M.
at the Division of Parks and Forestry Office
501 E. State Street
4th Floor Washington Conference Room
Trenton, NJ 08625

Persons wishing to make oral presentations are asked to limit their comments to a three to five minute time period. Presenters should bring a copy of their comments to the hearing for use by the Department. The hearing record will be kept open for a period of seven days following the date of the public hearing so that additional written comments can be received.

Anyone in need of special assistance to participate in the public hearing should please contact Carl R. Nordstrom, Deputy Director at (609) 292-2733.

Interested persons may submit written comments until December 27, 1993 to:

Gregory A. Marshall
Director
Division of Parks and Forestry
Department of Environmental Protection and Energy
CN 404
Trenton, New Jersey 08625

(d)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Northeast Water Quality Management Plan

Public Notice

Take notice that on October 13, 1993 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 Plan was adopted by the Department. This amendment, which was submitted on behalf of Bergen County, allows for transfer of Wastewater Management Plan (WMP) responsibility for the WMP area consisting of the existing Bergen County Utilities Authority (BCUA) district (excluding those portions also within the Passaic Valley Sewerage Commissioners District), and Rochelle Park Township. WMP responsibility for this area

will be transferred to Bergen County if and when the BCUA is dissolved and Bergen County as a result of that dissolution becomes owner and operator of the wastewater treatment plant located at the foot of Mehrhof Road in Little Ferry, Bergen County.

This amendment proposal was noticed in the New Jersey Register on June 21, 1993. Comments in opposition to the amendment were received from the BCUA during the public comment period and are summarized below with the Department's responses.

COMMENT: The petition to amend the Northeast Water Quality Management Plan (WQMP) indicates that the amendment would "transfer responsibility for the wastewater operations and services provided by the BCUA to the County of Bergen." While the County can seek planning responsibility as defined in N.J.A.C. 7:15-5.3(b), it has no authority to seek facility operating authority through the WQMP amendment process.

RESPONSE: The BCUA is correct in that the County can not seek to transfer responsibility for the wastewater operations and services provided by BCUA to the County as part of an amendment to the Northeast WQMP. As specified in the public notice for the amendment which was published in the June 21, 1993 New Jersey Register, and June 24, 1993 Star Ledger, the proposed amendment only addressed the transfer of WMP responsibility if and when the BCUA is dissolved. The amendment petition submitted on behalf of Bergen County has been revised to delete reference to transfer of responsibility for wastewater operations and services.

COMMENT: The BCUA indicates that there are a number of issues which need to be resolved prior to dissolution of the BCUA and that the amendment to transfer WMP responsibility is premature. The request for a WQMP amendment should come after dissolution has been fully implemented rather than prior to dissolution.

RESPONSE: The adopted amendment does not supersede the various issues which may need to be addressed as part of the dissolution of the BCUA. It only allows for WMP responsibility transfer to Bergen County if and when the BCUA is dissolved. It is appropriate for the amendment to be processed prior to dissolution of the BCUA since without the County as the WMP agency upon dissolution of the BCUA, WMP responsibility would automatically transfer to each municipality under N.J.A.C. 7:15-5.4 through 5.8.

(a)

OFFICE OF LAND AND WATER PLANNING

Amendment to the Upper Raritan Water Quality Management Plan

Public Notice

Take notice that the New Jersey Department of Environmental Protection and Energy (NJDEPE) is seeking public comment on a proposed amendment to the Upper Raritan Water Quality Management (WQM) Plan. This amendment, submitted on behalf of the Township of Tewksbury, would revise the Tewksbury Township Wastewater Management Plan (WMP). The amendment would reduce the sewer service area and size of the proposed Route 78 Office Service Area Sewage Treatment Plant (STP) to serve only Block 48, Lots 47 and 48, and Block 46.01, Lots 6.01, 7, 8, 9, 15, 16 and 17, all under the ownership of Bellemead Development Corporation, along the southerly side of Route 78. This STP will be privately owned, not municipally owned, as previously planned. The A.M. Best STP, originally slated to be abandoned, will continue to serve properties identified as Block 46, Lots 6 and 7.01 owned by A.M. Best. No expansion of the A.M. Best STP to serve beyond the A.M. Best properties is planned. The remainder of the Route 78 Office Service Area originally identified in the Tewksbury Township WMP as sewer service area of the Route 78 Office STP, will be identified as "On-Site Ground Water Disposal Areas For Facilities With Design Flows Of Less Than 20,000 Gallons Per Day."

This notice is being given to inform the public that a plan amendment has been proposed for the Upper Raritan WQM Plan. All information relating to the WQM Plan and the proposed amendment is located at the NJDEPE, Office of Land and Water Planning, CN423, 401 East State Street, 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 Land and Water Planning at (609) 633-1179.

Interested persons may submit written comments on the amendment to Dr. Daniel J. Van Abs, Office of Land and Water Planning, at the NJDEPE address cited above with a copy sent to Mr. John DeRiso, Brokaw DeRiso Associates, Inc., Post Office Box 5192, Clinton, New Jersey 08809. All comments must be submitted within 30 days of the date of this public notice. All comments submitted by interested persons in response to this notice, within the time limit, shall be considered by 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 30 days of the date of this public notice to Dr. Van Abs 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.

(b)

DIVISION OF SOLID WASTE MANAGEMENT AND WASTEWATER FACILITIES REGULATION PROGRAM

Statewide Sludge Management Plan Update Notice of Second Public Hearing and Extension of Public Comment Period DEPE Docket Number: 43-93-07

Take notice that, pursuant to N.J.S.A. 13:1E-1 et seq., the Division of Solid Waste Management and the Wastewater Facilities Regulation Program of the Department of Environmental Protection and Energy (DEPE) will hold a **second public hearing** on the proposed Statewide Sludge Management Plan Update as follows:

Wednesday, December 1, 1993
6:00 P.M. to 9:00 P.M.
Liberty State Park Interpretive Center
Wolf Drive
Jersey City, New Jersey

The DEPE is extending the comment period as well. **Submit written comments,** identified by the Docket Number given above, by December 15, 1993, to:

Janis E. Hoagland, Administrative Practice Officer
NJDEPE Office of Legal Affairs
CN-402
Trenton, New Jersey 08625-0402

The purpose of the hearing is to receive oral and written comments on Section III of the DEPE's Solid Waste Management Plan Update concerning the Statewide Sludge Management Plan Update (hereafter SSMP Update). Pursuant to N.J.S.A. 13:1E-1 et seq., the DEPE has formulated, developed and periodically updated a Statewide plan for the environmentally sound management of sewage sludge generated within New Jersey. The SSMP Update includes the various guidelines, recommendations for rules and regulations, and goals, objectives and policies of the DEPE; guidance for the sludge management planning process; and other sludge planning and program components developed to address the State's sludge management needs.

Notice of the first public hearing was published in the September 7, 1993, New Jersey Register at 25 N.J.R. 4336(c). The DEPE, in response to public inquiries and recommendations, has scheduled a second hearing in the northern region of the State due to the numerous pending projects that involved sewage authorities in this region. Additionally, the DEPE has extended the written comment period to provide ample opportunity for the public to participate and comment on the proposed SSMP Update.

After this second public hearing, the DEPE will carefully review all comments relevant to the SSMP Update and will prepare a document summarizing the comments and the DEPE's responses thereto, including revisions to the proposed SSMP Update that the DEPE deems necessary and appropriate. Following this, the DEPE intends to adopt the SSMP Update as Section III of the overall Solid Waste Management Plan.

Copies of the proposed SSMP Update are available at all libraries in the State Library depository system, at all county solid waste management offices and have been distributed to all domestic wastewater treat-

ment facilities in New Jersey. In addition, copies may be obtained by writing to the DEPE's Division of Solid Waste Management (DSWM), Bureau of Medical Waste, Residuals Management and Statewide Planning, 840 Bear Tavern Road, Trenton, New Jersey 08625-0414, or by calling the DSWM at (609) 530-8599.

HUMAN SERVICES

(a)

DIVISION OF FAMILY DEVELOPMENT

Food Stamp Program
Notice of Food Stamp Income Eligibility, Deduction, and Coupon Allotment Standards

In accordance with N.J.A.C. 10:87-12, the Department of Human Services announces that the following food stamp income eligibility, deduction, and coupon allotment standards shall be utilized in the New Jersey Food Stamp Program for the period October 1, 1993 through September 30, 1994. This change became effective October 1, 1993.

Table I
Income Deductions

Standard Deduction (N.J.A.C. 10:87-12.1(a))	$131.00
Shelter Deduction (N.J.A.C. 10:87-12.1(b))	$207.00
Uniform Telephone Allowance (UTA) (N.J.A.C. 10:87-12.1(c))	$ 18.00
Standard Utility Allowance (SUA) (N.J.A.C. 10:87-12.1(d))	$128.00
Heating Utility Allowance (HUA) (N.J.A.C. 10:87-12.1(e))	$205.00
Homeless Shelter Allowance (HSA) (N.J.A.C. 10:87-12.1(f))	$137.00

Table II
Maximum Coupon Allotment (MCA)
(N.J.A.C. 10:87-12.2)

Household Size	MCA
1	$112.00
2	206.00
3	295.00
4	375.00
5	446.00
6	535.00
7	591.00
8	676.00
Each Additional Member	+85.00

Table III
Maximum Allowable Net Income
(N.J.A.C. 10:87-12.3)

Household Size	Maximum Allowable Income
1	$ 581.00
2	786.00
3	991.00
4	1196.00
5	1401.00
6	1606.00
7	1811.00
8	2016.00
Each Additional Member	+205.00

Table IV
Maximum Allowable Gross Income
(N.J.A.C. 10:87-12.4)

Household Size	Maximum Allowable Income
1	$ 756.00
2	1022.00
3	1289.00
4	1555.00
5	1822.00
6	2088.00
7	2355.00
8	2621.00
Each Additional Member	+267.00

Table VII
165 Percent of Poverty Level
(N.J.A.C. 10:87-12.7)

Household Size	Maximum Allowable Income
1	$ 959.00
2	1297.00
3	1635.00
4	1974.00
5	2312.00
6	2650.00
7	2988.00
8	3327.00
Each Additional Member	+339.00

CORRECTIONS

(b)

THE COMMISSIONER

Notice of Receipt of Petition for Rulemaking
N.J.A.C. 10A:4-9.15(c)

Petitioner: George R. Jacques, New Jersey State Prison.

Take notice that on October 7, 1993, the Department of Corrections received a petition for rulemaking at N.J.A.C. 10A:4-9.15(c), the Department's rules concerning Inmate Discipline—Evidence Required.

The petitioner requests that the Department amend N.J.A.C. 10A:4-9.15 by adding a subsection (c) which states that the Disciplinary Hearing Officer shall require a report from any treating physician/psychologist/psychiatrist when in the event an inmate is charged with a disciplinary infraction, and at the time of the alleged misconduct the inmate is exhibiting any of the following:

1. Hallucinations (visual or auditory);
2. Delusions motivating or commanding the prisoner to harm himself or others or to perform dangerous behavior;
3. Acute psychotic episodes or acute exacerbation of psychotic symptoms from previous 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 unacceptable;
5. Total body rigidity or immobility (catatonia);
6. Severe and disabling anxiety; or
7. Severely disabling thought disorder.

The petitioner suggests that the report from any treating physician/psychologist/psychiatrist shall consist of:

1. Whether the inmate's current mental status precludes participation in the disciplinary process;
2. Whether the inmate's mental status contributed to the alleged disciplinary offense; and/or
3. Whether the inmate's mental status contraindicates any particular form of punishment.

The petitioner further suggests that if the Disciplinary Hearing Officer finds that any of the above three mental conditions exist, the Disciplinary

Hearing Officer shall dismiss the misconduct report and refer the inmate to the appropriate institutional psychiatrist/psychologist for treatment, or possible commitment to the Forensic Psychiatric Hospital if the treating physician finds 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. Delusions motivating or commanding the prisoner to harm self or others or to perform dangerous behavior; and/or
9. Paranoid hallucinations/delusions, so severe that the prisoner is unable to perform basic care needs, such as eating, drinking and/or personal hygiene.

In accordance with the provisions of N.J.S.A. 52:14B-4(f) and N.J.A.C. 1:30-3.6, the Department shall subsequently mail to the petitioner, and file with the Office of Administrative Law, a Notice of Action on the Petition.

INSURANCE

(a)

DIVISION OF PROPERTY AND CASUALTY

Public Notice
List of Special Risks

Take notice that effective October 14, 1993 Samuel F. Fortunato, Commissioner of Insurance, pursuant to the authority of the Commercial Insurance Deregulation Act of 1982 (N.J.S.A. 17:29AA-1 et seq.), hereby promulgates the list of special risks described in N.J.S.A. 17:29AA-3k. This list was last published November 5, 1982 at 14 N.J.R. 1404(a). The Department has added Section F (Special Risk Exceptions) in order to clarify which risks are specifically excepted from being special risks.

The following commercial lines insurance risks are special risks:

1. Risks which are written on an excess or umbrella basis;
2. Risks which are eligible for export as set forth on any current list of exportables promulgated by the Commissioner under N.J.S.A. 17:22-6.43; or
3. Those commercial lines insurance risks, or portions thereof which: (a) do not appear in any of the following manuals, rating plans or schedules below; (b) are excepted below from such manuals, rating plans or schedules; or (c) are specifically designated special risks below, are found to be special risks which are of an unusual nature or high loss hazard or are difficult to place or rate.

I. **RATING ORGANIZATION MANUALS, RATING PLANS, OR SCHEDULE AND EXCEPTIONS**
- A. **INSURANCE SERVICES OFFICE**
  1. **COMMERCIAL LINES MANUAL** (including Commercial Automobile Supplementary Rating Procedures)
  Except risks which are designated as:
    (a) "a" rated
    (b) "refer to company" either exclusively or in the alternative
    (c) "Submit to company"
    (d) Property owned by the Federal government
    (e) Railroad property
    (f) Computer fraud risks
    (g) Extortion risks
  2. **COMMERCIAL AUTOMOBILE SUPPLEMENTARY RATING PROCEDURES**
- B. **MUTUAL SERVICE OFFICE**
  SPECIAL MULTI PERIL MANUAL, BURGLARY AND THEFT
  MANUAL FIRE AND ALLIED LINES MANUAL
  Except risks designated as:
  1. "a" rated
  2. "refer to company" either exclusively or in the alternative
  3. "submit to company"
- C. **CROP-HAIL INSURANCE ACTUARIAL ASSOCIATION MANUAL**
- D. **AMERICAN ASSOCIATION OR INSURANCE SERVICES GENERAL LIABILITY MANUAL**
  Except risks as designated as:
  1. "a" rated
  2. "refer to company" either exclusively or in the alternative
  3. "submit to company"
- E. **MILL AND ELEVATOR RATING BUREAU MANUAL**
- F. **SPECIAL RISK EXCEPTIONS**
  Notwithstanding anything aforesaid, the following risks are not special risks and are specifically excepted from the special risks list:
  1. Legal malpractice liability
  2. Medical malpractice liability
  3. Hospitals professional liability
  4. Physicians and surgeons professional liability
  5. Dentist professional liability
  6. Employees professional liability
  7. Nurses professional liability
  8. Optometrists professional liability
  9. Physiotherapists professional liability
  10. Chiropodists professional liability

II. **SPECIFICALLY DESIGNATED SPECIAL RISKS**
- A. **INSURANCE SERVICES OFFICE**
  1. Risks rate under any of the following schedules are special risks:
    (a) Petroleum properties
    (b) Petrochemicals plans
    (c) Electric generating stations
    (d) Natural gas pumping stations
    (e) Coal, oil and water gas plants
    (f) Electric traction properties
  2. Risks insured under the provisions of the Highly Protected Risks Rating Plan are special risks.
- B. Preferred risk properties insured and rated as shown in the rules and rating schedules of the **FACTORY MUTUAL SERVICE BUREAU** are special risks.
- C. All commercial insurance aviation risks (including those rates from the **AVIATION INSURANCE RATING BUREAU** Schedule of Rates) are special risks.
- D. All nuclear insurance risks are special risks.
- E. All Animal Mortality risks are special risks.
- F. All Credit Insurance risks are special risks.
- G. All Boiler and Machinery risks are special risks.

TREASURY-TAXATION

(b)

DIVISION OF TAXATION

Sanitary Landfill Taxes
Notice of 1994 Tax Rate Changes

Take notice that the owners and operators of all sanitary landfill facilities in New Jersey that accept solid waste for disposal are required to file Consolidated Sanitary Landfill Tax Returns (Form SLT-5) on a monthly basis. The five sanitary landfill taxes—the Solid Waste Recycling Tax, the Landfill Closure and Contingency Tax, the Solid Waste Services Tax, the Resource Recovery Investment Tax, and the Solid Waste Importation Tax—are reportable on this consolidated return.

This notice is to advise sanitary landfill taxpayers of the tax rate changes provided for by law, effective January 1, 1994 for the sanitary landfill taxes.

Please take notice that effective January 1, 1994:

1. The Solid Waste Services Tax increases from $0.90 per ton or $0.27 per cubic yard to $0.95 per ton or $0.285 per cubic yard (see N.J.S.A. 13:1E-138a);
2. The Solid Waste Importation Tax increases from $14.00 per ton or $4.20 per cubic yard to $16.00 per ton or $4.80 per cubic yard (see N.J.S.A. 13:1E-138c);
3. The Landfill Closure and Contingency Tax remains unchanged at $0.50 per ton or $0.15 per cubic yard (see N.J.S.A. 13:1E-104a);
4. The Solid Waste Recycling Tax remains unchanged at $1.50 per ton or $0.45 per cubic yard (see N.J.S.A. 13:1E-95); and

5. The Resource Recovery Investment Tax remains unchanged at $4.00 per ton or $1.20 per cubic yard (see N.J.S.A. 13:1E-138b).

The tax rates for all solid waste in liquid form, reportable in gallons, remain the same for all sanitary landfill taxes. Any taxpayer who fails to comply with the new rates will be assessed tax, penalty and interest on any calculated balance of tax due.

Return packages containing the 1994 Consolidated Sanitary Landfill Tax Returns (Form SLT-5) with accompanying schedules and Instructions (Form SLT-5A) will be mailed to all taxpayers after January 1, 1994. Any inquiries regarding the Sanitary Landfill Taxes may be directed to: Special Audit Section, Division of Taxation, 50 Barrack Street, Trenton, NJ 08646, Telephone (609) 292-5300.

OTHER AGENCIES

(a)

NEW JERSEY HIGHWAY AUTHORITY

Garden State Parkway
Notice of Receipt of Petition for Rulemaking
N.J.A.C. 19:8-9.1, Permits for Outdoor Advertising

Petitioner: Richard D. Merion, Vice President Barnegat Bay Trading Co.

Nature of request for rulemaking action:

Mr. Merion requests that the New Jersey Highway Authority modify its regulation N.J.A.C. 19:8-9.1 to permit placement of logos of off-roadway businesses, such as restaurants and motels, on on-roadway signs near the exits that lead to access to these businesses.

The purpose of the request is to aid small businesses that depend on tourists for their livelihood.

This petition was received on September 13, 1993.

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 October 4, 1993 issue.

If you need to retain a copy of all currently proposed rules, you must save the last 12 months of Registers. A proposal may be adopted up to one year after its initial publication in the Register. Failure to adopt a proposed rule on a timely basis requires the proposing agency to resubmit the proposal and to comply with the notice and opportunity-to-be-heard requirements of the Administrative Procedure Act (N.J.S.A. 52:14B-1 et seq.), as implemented by the Rules for Agency Rulemaking (N.J.A.C. 1:30) of the Office of Administrative Law. If an agency allows a proposed rule to lapse, "Expired" will be inserted to the right of the Proposal Notice N.J.R. Citation in the next Register following expiration. Subsequently, the entire proposal entry will be deleted from the Index. See: N.J.A.C. 1:30-4.2(c).

Terms and abbreviations used in this Index:

N.J.A.C. Citation. The New Jersey Administrative Code numerical designation for each proposed or adopted rule entry.

Proposal Notice (N.J.R. Citation). The New Jersey Register page number and item identification for the publication notice and text of a proposed amendment or new rule.

Document Number. The Registry number for each adopted amendment or new rule on file at the Office of Administrative Law, designating the year of promulgation of the rule and its chronological ranking in the Registry. As an example, R.1993 d.1 means the first rule filed for 1993.

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 SEPTEMBER 20, 1993

NEXT UPDATE: SUPPLEMENT OCTOBER 18, 1993

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
24 N.J.R. 4145 and 4306	November 16, 1992	25 N.J.R. 2151 and 2620	June 7, 1993
24 N.J.R. 4307 and 4454	December 7, 1992	25 N.J.R. 2621 and 2794	June 21, 1993
24 N.J.R. 4455 and 4606	December 21, 1992	25 N.J.R. 2795 and 3050	July 6, 1993
25 N.J.R. 1 and 218	January 4, 1993	25 N.J.R. 3051 and 3276	July 19, 1993
25 N.J.R. 219 and 388	January 19, 1993	25 N.J.R. 3277 and 3582	August 2, 1993
25 N.J.R. 389 and 616	February 1, 1993	25 N.J.R. 3583 and 3884	August 16, 1993
25 N.J.R. 619 and 736	February 16, 1993	25 N.J.R. 3885 and 4360	September 7, 1993
25 N.J.R. 737 and 1030	March 1, 1993	25 N.J.R. 4361 and 4540	September 20, 1993
25 N.J.R. 1031 and 1308	March 15, 1993	25 N.J.R. 4541 and 4694	October 4, 1993
25 N.J.R. 1309 and 1620	April 5, 1993	25 N.J.R. 4695 and 4812	October 18, 1993
25 N.J.R. 1621 and 1796	April 19, 1993	25 N.J.R. 4813 and 4980	November 1, 1993
25 N.J.R. 1797 and 1912	May 3, 1993	25 N.J.R. 4981 and 5382	November 15, 1993
25 N.J.R. 1913 and 2150	May 17, 1993		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ADMINISTRATIVE LAW—TITLE 1				
1:10-1.1, 9.1, 9.2, 14.1, 14.2, 14.3, 18.1	Family Development hearings	25 N.J.R. 3888(a)		
	Most recent update to Title 1: TRANSMITTAL 1993-2 (supplement September 20, 1993)			
AGRICULTURE—TITLE 2				
2:68	Commercial feeding stuffs	25 N.J.R. 3889(a)		
2:69	Commercial fertilizers and soil conditioners	25 N.J.R. 4544(a)		
2:69-1.11	Commercial values of primary plant nutrients	25 N.J.R. 3585(a)		
2:76-5.1-5.4	Soil and water conservation project cost-sharing	25 N.J.R. 3279(a)	R.1993 d.521	25 N.J.R. 4899(a)
2:76-6.11	Farmland Preservation Program: acquisition of development easements	25 N.J.R. 3890(a)		
2:76-6.11	Farmland Preservation Program: correction to proposal and extension of comment period regarding acquisition of development easements	25 N.J.R. 4697(a)		
	Most recent update to Title 2: TRANSMITTAL 1993-5 (supplement August 16, 1993)			
BANKING—TITLE 3				
3:1-13.2	Mortgage loans: fire insurance amount	25 N.J.R. 3585(b)	R.1993 d.520	25 N.J.R. 4900(a)
3:3-2.2, 2.3	Release of bank examination reports to independent auditors	25 N.J.R. 4819(a)		
3:4-1.6	Capital for interim conversion in merger or acquisition	25 N.J.R. 4545(a)		
3:4-2	Payment of stock options to directors, officers and employees of State depositories	25 N.J.R. 3586(a)	R.1993 d.565	25 N.J.R. 5145(a)
3:6-15.2	Disqualification of savings bank directors	25 N.J.R. 3586(b)		
3:11-7.11	Disqualification of bank directors	25 N.J.R. 3586(b)		
3:28-4.7, 4.12	Repair and improvement loans	25 N.J.R. 3587(a)	R.1993 d.517	25 N.J.R. 4900(b)
3:31	Repeal (see 3:28-4.7, 4.12)	25 N.J.R. 3587(a)	R.1993 d.517	25 N.J.R. 4900(b)
3:32	Conversion of associations and savings banks	25 N.J.R. 2799(a)	R.1993 d.535	25 N.J.R. 4900(c)
3:38-1.1, 1.10, 5.1	Mortgage banker non-servicing	25 N.J.R. 1035(a)		
3:41-2.1, 11	Cemetery Board: location of interment spaces and path access	25 N.J.R. 623(a)		
3:41-5.1	Cemetery Board: cemetery company price lists	25 N.J.R. 4819(b)		
	Most recent update to Title 3: TRANSMITTAL 1993-7 (supplement September 20, 1993)			
CIVIL SERVICE—TITLE 4				
	Most recent update to Title 4: TRANSMITTAL 1992-1 (supplement September 21, 1992)			
PERSONNEL—TITLE 4A				
4A:1-5	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1314(c)		
4A:3-4.10	State service: demotional pay adjustments	25 N.J.R. 4821(a)		
4A:4-2.2, 2.14	Equal employment opportunity	25 N.J.R. 4821(b)		
4A:4-2.9	Make-up examinations	25 N.J.R. 4823(a)		
4A:4-2.11	Residence requirements: administrative correction	_____	_____	25 N.J.R. 5145(b)
4A:4-7.8	Voluntary demotions	25 N.J.R. 4823(b)		
4A:6-1.2, 1.6, 1.11, 1.12, 1.13	Leaves of absence	25 N.J.R. 4824(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
4A:6-1.3	Equal employment opportunity	25 N.J.R. 4821(b)		
4A:7-1.1, 2.1, 2.2, 2.3, 3.1	Equal employment opportunity	25 N.J.R. 4821(b)		

Most recent update to Title 4A: TRANSMITTAL 1993-5 (supplement September 20, 1993)

COMMUNITY AFFAIRS—TITLE 5

5:10-1.12	Hotels and multiple dwellings: administrative correction	_____	_____	25 N.J.R. 4901(a)
5:18-1.4, 1.5, 2.1, 2.3, 2.5, 2.6, 2.11, 2.14, 4.1, 4.3	Uniform Fire Code	25 N.J.R. 4363(a)		
5:18-3.2, 3.3, 3.13, 3.19, App. 3A	Fire Prevention Code: junk yards, recycling centers, and other exterior storage sites	25 N.J.R. 1315(b)		
5:18-4.3, 4.7	Fire Safety Code: fire suppression systems in hospitals and nursing homes	25 N.J.R. 1316(a)		
5:18A-1.4, 2.2, 2.3, 2.5–2.11, 3.3, 3.4, 3.6, 4.2–4.6, 4.9, 4.10	Fire Code enforcement	25 N.J.R. 4363(a)		
5:18B-2.8	High level alarms	25 N.J.R. 4363(a)		
5:18C-1.4, 1.5, 1.7, 1.8, 1.9, 2.3	Fire service training and certification	25 N.J.R. 4363(a)		
5:23-1.4, 2.7, 2.17A	Uniform Construction Code: minor work; ordinary repairs	25 N.J.R. 3692(a)	R.1993 d.580	25 N.J.R. 5145(c)
5:23-2.6, 2.14, 2.23, 3.2, 3.4, 3.8A, 3.11A, 3.14–3.18, 3.20, 3.20A, 3.21, 4.3A, 4A.8, 4A.11, 12.2	Uniform Construction Code: subcodes	25 N.J.R. 3891(a)		
5:23-2.7, 9.3	Uniform Construction Code: ordinary repairs; interpretation	25 N.J.R. 2159(a)	R.1993 d.487	25 N.J.R. 4592(a)
5:23-2.17A	Uniform Construction Code: reroofing work	25 N.J.R. 4546(a)		
5:23-2.18A, 3.11, 4.20	UCC: utility load management device permits; mausoleum plan review; Department fees	25 N.J.R. 4546(b)		
5:23-4.4, 4.5, 4.5A, 4.12, 4.14, 4.18, 4.20	Uniform Construction Code: private on-site inspection agencies	25 N.J.R. 2162(a)		
5:23-4.5	Uniform Construction Code: "Notice of Elevator Device Sealed Out of Operation"	25 N.J.R. 3693(a)	R.1993 d.581	25 N.J.R. 5146(a)
5:23-4.18	UCC: subcode training registration fee	25 N.J.R. 4548(a)		
5:26-8.2	Meetings of community associations	25 N.J.R. 3693(b)	R.1993 d.522	25 N.J.R. 4901(b)
5:50	State Review Process for intergovernmental review of applications for Federal financial assistance and direct development activities	25 N.J.R. 3281(a)	R.1993 d.505	25 N.J.R. 4743(a)
5:80-23.9	Housing and Mortgage Finance Agency: Housing Incentive Note Purchase Program fees	25 N.J.R. 3053(a)		
5:80-24	Housing and Mortgage Finance Agency: Lease-Purchase Program	25 N.J.R. 4826(a)		
5:80-26.19	Housing and Mortgage Finance Agency: affordable housing controls	25 N.J.R. 4369(a)		
5:80-29	Housing and Mortgage Finance Agency: investment of housing project funds	25 N.J.R. 4830(a)		
5:80-32	Housing and Mortgage Finance Agency: housing investment sales	25 NJ.R. 4828(a)		
5:92-1.1	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		
5:93	Council on Affordable Housing: substantive rules	25 N.J.R. 1118(a)		

Most recent update to Title 5: TRANSMITTAL 1993-9 (supplement September 20, 1993)

MILITARY AND VETERANS' AFFAIRS—TITLE 5A

5A:7-1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1317(a)		

Most recent update to Title 5A: TRANSMITTAL 1992-2 (supplement September 21, 1992)

EDUCATION—TITLE 6

6:1 et seq.	Title 6, New Jersey Administrative Code: opportunity for public comment	25 N.J.R. 4369(b)		
6:2	Appeals to State Board of Education	25 N.J.R. 4548(b)		
6:22A	School facility lease purchase agreements	25 N.J.R. 3588(a)	R.1993 d.544	25 N.J.R. 4901(c)
6:28-4.1	Special education: administrative correction	_____	_____	25 N.J.R. 4743(b)
6:78	Marie H. Katzenbach School for the Deaf	25 N.J.R. 3592(a)	R.1993 d.543	25 N.J.R. 4904(a)

Most recent update to Title 6: TRANSMITTAL 1993-6 (supplement August 16, 1993)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
ENVIRONMENTAL PROTECTION AND ENERGY—TITLE 7				
7:0	Green glass marketing and recycling: request for public input on feasibility study	25 N.J.R. 1654(a)		
7:0	Regulated Medical Waste Management Plan: public hearing and opportunity for comment	25 N.J.R. 1654(b)		
7:0	Site Remediation Program: analysis of strict, joint and several liability under the New Jersey Spill Compensation Act	25 N.J.R. 3694(a)		
7:1D	Allocation of water supply costs for emergency water projects	25 N.J.R. 2635(a)	R.1993 d.497	25 N.J.R. 4595(a)
7:1E	Discharges of petroleum and other hazardous substances: request for public comment on draft amendments	25 N.J.R. 2636(a)		
7:1G-1–5, 7	Worker and Community Right to Know	25 N.J.R. 1631(a)		
7:1G-2.1, 6.4	Environmental Hazardous Substances and Industrial Survey lists: copper phthalocyanine compounds; confidentiality	25 N.J.R. 2166(a)		
7:1K-1.5, 3.1, 3.4, 3.9-3.11, 4.3, 4.5, 4.7, 5.1, 5.2, 6.1, 6.2, 7.2, 7.3, 9.2-9.5, 9.7, 12.6-12.9	Pollution Prevention Program requirements	25 N.J.R. 1849(a)		
7:2-2.20, 3.6, 6.4, 8.4, 8.6, 10.2, 16.5, 17.1, 17.3, 17.4, 17.5	State Park Service Code	25 N.J.R. 2799(b)		
7:4B	Historic Preservation Revolving Loan Program	25 N.J.R. 748(a)		
7:7A-1.4, 2.7	Freshwater Wetlands Protection Act rules: definition of project	25 N.J.R. 1642(a)		
7:7E-7.4	Coastal zone management: Outer Continental Shelf oil and gas exploration and development	25 N.J.R. 5(a)	R.1993 d.549	25 N.J.R. 5146(b)
7:9-1.1	Treatment works approval, sewer bans and sewer ban exemptions	25 N.J.R. 3282(a)		
7:9-4 (7:9B)	Surface water quality standards; draft Practical Quantitation Levels; total phosphorus limitations and criteria: extension of comment periods and notice of roundtable discussion	25 N.J.R. 404(a)		
7:9-4 (7:9B-1), 6.3	Surface water quality standards	24 N.J.R. 3983(a)		
7:9-4.14, 4.15 (7:9B-1.14, 1.15)	Surface water quality standards: administrative corrections to proposal	24 N.J.R. 4471(a)		
7:9-4.15	Water surface quality standards: Wallkill River	25 N.J.R. 3755(a)		
7:13-7.1	Delaware River, Pohatcong Township: flood plain redelineation	25 N.J.R. 4370(a)		
7:13-7.1	Overpeck Creek, Englewood: flood plain redelineation	25 N.J.R. 4371(a)		
7:13-7.1	Poplar Brook, Deal: flood plain redelineation	25 N.J.R. 4372(a)		
7:14A	NJPDES Program: opportunity for interested party review of permitting system	25 N.J.R. 411(a)		
7:14A	NJPDES Program: extension of comment period for interested party review of permitting system	25 N.J.R. 1863(a)		
7:14A-1.9, 3.14	Surface water quality standards	24 N.J.R. 3983(a)		
7:14A-1.9, 12, 22, 23	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:14A-2.5	NJPDES Program: administrative correction regarding permittee requirements	_____	_____	25 N.J.R. 4791(a)
7:14B-1.6, 2.2, 2.6, 2.7, 2.8, 3.1–3.8	Underground Storage Tanks Program fees	25 N.J.R. 1363(a)		
7:15-5.18	Treatment works approval, sewer bans and exemptions	25 N.J.R. 3282(a)		
7:20A	Water usage certifications for agricultural or horticultural purposes	25 N.J.R. 3956(a)		
7:25-6	1994-95 Fish Code	25 N.J.R. 3053(b)	R.1993 d.526	25 N.J.R. 4905(a)
7:25-7.13, 14.1, 14.2, 14.4–14.8, 14.10–14.13	Crab management	25 N.J.R. 4831(a)		
7:25-11	Introduction of imported or non-native shellfish or finfish into State's marine waters	24 N.J.R. 3660(a)	Expired	
7:25-18.1, 18.14	Summer flounder permit conditions	25 N.J.R. 2167(a)		
7:25A-1.2, 1.4, 1.9, 4.3	Oyster management	25 N.J.R. 754(a)		
7:26-1.4, 9.3	Hazardous waste management: satellite accumulation areas	25 N.J.R. 1864(a)		
7:26-1.9, 11.4, 12.9	Waste management: administrative corrections	_____	_____	25 N.J.R. 4595(b)
7:26-2.11, 2.13, 2B.9, 2B.10, 6.2, 6.8	Solid waste flow through transfer stations and materials recovery facilities	24 N.J.R. 3286(c)	R.1993 d.508	25 N.J.R. 4763(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
7:26-6.6	Procedure for modification of waste flows	25 N.J.R. 991(a)		
7:26-8.8, 8.12, 8.19	Handling of substances displaying the Toxicity Characteristic	25 N.J.R. 753(a)		
7:26-12.3	Hazardous waste management: interim status facilities	24 N.J.R. 4253(a)		
7:26B-1.3, 1.10, 1.11, 1.12	Environmental Cleanup Responsibility Act Program fees	25 N.J.R. 1375(a)		
7:26C	Site Remediation Program: opportunity for comment on draft remedial priority system	25 N.J.R. 4551(c)		
7:27-1, 8, 18, 22	Air pollution control: facility operating permits	25 N.J.R. 3963(a)		
7:27-1, 8, 18, 21, 22	Air pollution control: extension of comment period regarding facility operating permits, emission statements, and penalties	25 N.J.R. 4836(a)		
7:27-1.4, 2.1, 8.1, 8.2, 16, 17.1, 17.3, 17.4, 23.1-23.7, 25.1, 25.7	Air pollution by volatile organic compounds: control and prohibition	25 N.J.R. 3339(a)		
7:27-1.4, 2.1, 8.1, 8.2, 16, 17.1, 17.3, 17.4, 23.1–23.7, 25.1, 25.7	Air pollution control: extension of comment period	25 N.J.R. 4551(a)		
7:27-15.1, 15.2, 15.4-15.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:27-19	Control and prohibition of air pollution from oxides of nitrogen	25 N.J.R. 631(a)		
7:27-21.1–21.5, 21.8, 21.9, 21.10	Air pollution control: facility emission statements	25 N.J.R. 4033(a)		
7:27-25.1, 25.3, 25.4, 25.9, 25.10, 25.11, 25.12	Oxygenated fuels program	25 N.J.R. 4039(a)		
7:27-26	Low Emissions Vehicle Program	25 N.J.R. 1381(a)		
7:27A-3.2, 3.5, 3.10	Air pollution control: administrative penalties and requests for adjudicatory hearings	25 N.J.R. 4045(a)		
7:27A-3.2, 3.10	Air pollution civil administrative penalties	25 N.J.R. 3339(a)		
7:27A-3.2, 3.10	Air pollution civil administrative penalties: extension of comment period	25 N.J.R. 4551(a)		
7:27A-3.5, 3.10	Control and prohibition of air pollution from oxides of nitrogen: civil administrative penalties	25 N.J.R. 631(a)		
7:27A-3.10	Air pollution control: facility emission statement penalties	25 N.J.R. 4033(a)		
7:27A-3.10	Oxygenated fuels program penalties	25 N.J.R. 4039(a)		
7:27B-3.1, 3.10	Air pollution sampling and analytical procedures	25 N.J.R. 3339(a)		
7:27B-3.1, 3.10	Air pollution sampling and analytical procedures: extension of comment period	25 N.J.R. 4551(a)		
7:27B-4.1, 4.5–4.10	Air quality management: enhanced inspection and maintenance program	25 N.J.R. 3322(a)		
7:28-15	Medical diagnostic X-ray installations: administrative correction	_____	_____	25 N.J.R. 5148(a)
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations	25 N.J.R. 7(a)	R.1993 d.510	25 N.J.R. 4770(a)
7:28-15, 16.2, 16.8	Medical diagnostic x-ray installations; dental radiographic installations; extension of comment period	25 N.J.R. 1039(a)		
7:36	Green Acres Program: opportunity to review draft rule revisions	25 N.J.R. 1473(a)		
7:31-2.5, App. I	Toxic Catastrophe Prevention Act rules: administrative corrections	_____	_____	25 N.J.R. 4791(b)
7:36	Green Acres Grant Program	25 N.J.R. 3405(a)		
7:45	Delaware and Raritan Canal State Park Review Zone	25 N.J.R. 4836(b)		

Most recent update to Title 7: TRANSMITTAL 1993-9 (supplement September 20, 1993)

HEALTH—TITLE 8				
8:2A-1	Access to death records	25 N.J.R. 3115(a)		
8:21-10.1, 10.2, 10.4, 10.6, 10.12	Milk and fluid milk products	25 N.J.R. 4373(a)		
8:23-6	Pilot low-cost spaying and neutering clinic surgery fees	25 N.J.R. 3116(a)	R.1993 d.568	25 N.J.R. 5148(a)
8:24	Packing of refrigerated foods in reduced oxygen packages by retail establishments: preproposal	25 N.J.R. 660(b)		
8:25-2.1, 2.3	Youth Camp Safety Act standards: administrative corrections	_____	_____	25 N.J.R. 4744(a)
8:31B	Hospital financing	25 N.J.R. 3117(a)	R.1993 d.593	25 N.J.R. 5149(a)
8:31B	Hospital financing: correction to proposal	25 N.J.R. 3566(a)		
8:31B-3.41, 4.38, 4.39, 4.40, 7	Hospital reimbursement: uncompensated care	25 N.J.R. 3125(a)		
8:31B-4.41-4.41N	Hospital reimbursement: charity care audit functions	25 N.J.R. 3707(a)	R.1993 d.592	25 N.J.R. 5154(a)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
8:33A-1.2, 1.16	Hospital Policy Manual: applicant preference; equity requirement	24 N.J.R. 4476(a)		
8:33A-1.10, 1.16, 1.29	Hospital Policy Manual: capital cap and review process	25 N.J.R. 3710(a)	R.1993 d.570	25 N.J.R. 5161(a)
8:33E	Cardiac diagnostic facilities and surgery centers: certificate of need	25 N.J.R. 3712(a)		
8:33H	Long-term care services: certificate of need policy	25 N.J.R. 3719(a)		
8:33S	Surgical facilities: certificate of need	25 N.J.R. 2790(a)	R.1993 d.498	25 N.J.R. 4626(a)
8:34	Nursing home administrators: standards for licensing	25 N.J.R. 3727(a)	R.1993 d.545	25 N.J.R. 4908(a)
8:36	Assisted living residences and comprehensive personal care homes: standards for licensure	25 N.J.R. 3734(a)		
8:40-1.1, 2.3, 2.7, 3.1, 4.12, 5.23, 6.26	Invalid coach and ambulance services: licensure; street EMS	25 N.J.R. 2663(a)	R.1993 d.594	25 N.J.R. 5163(a)
8:41-4.1, 10.5-10.13, 11	Mobile intensive care programs: standing orders; paramedic clinical training objectives	25 N.J.R. 2665(a)		
8:43	Licensure of residential health care facilities	25 N.J.R. 25(a)	R.1993 d.473	25 N.J.R. 4631(a)
8:43	Licensure of residential health care facilities: public hearing	25 N.J.R. 757(a)		
8:44	Operation of clinical laboratories	25 N.J.R. 3904(a)	R.1993 d.595	25 N.J.R. 5164(a)
8:44-2.1, 2.14	Clinical laboratory licensure: HIV testing	25 N.J.R. 2184(a)		
8:44-2.11	Clinical laboratories: reporting by supervisors	25 N.J.R. 3751(a)		
8:57-3.2	Physician reporting of occupational and environmental diseases and injuries	25 N.J.R. 2186(a)	R.1993 d.569	25 N.J.R. 5164(b)
8:59-5.6	Worker and Community Right to Know: exclusions from labeling requirements	25 N.J.R. 3441(a)		
8:59-App. A, B	Worker and Community Right to Know Act: preproposal concerning Hazardous Substance List and Special Health Hazard Substance List	25 N.J.R. 792(a)		
8:71	Interchangeable drug products (see 24 N.J.R. 2557(b), 3173(a), 4260(b); 25 N.J.R. 582(a))	24 N.J.R. 1674(a)	R.1993 d.226	25 N.J.R. 1970(b)
8:71	Interchangeable drug products (see 24 N.J.R. 3174(c), 3728(a), 4262(a); 25 N.J.R. 583(a))	24 N.J.R. 2414(b)	R.1993 d.338	25 N.J.R. 2882(b)
8:71	Interchangeable drug products (see 24 N.J.R. 4261(a); 25 N.J.R. 582(b))	24 N.J.R. 2997(a)	R.1993 d.225	25 N.J.R. 1970(a)
8:71	Interchangeable drug products (see 25 N.J.R. 580(b), 2883(a))	24 N.J.R. 4009(a)	R.1993 d.468	25 N.J.R. 4497(a)
8:71	Interchangeable drug products (see 25 N.J.R. 1221(a), 1969(c), 2882(a))	25 N.J.R. 55(a)	R.1993 d.467	25 N.J.R. 4496(b)
8:71	Interchangeable drug products (see 25 N.J.R. 1970(c), 2881(b))	25 N.J.R. 875(a)	R.1993 d.469	25 N.J.R. 4497(b)
8:71	Interchangeable drug products (see 25 N.J.R. 2881(a))	25 N.J.R. 1814(b)	R.1993 d.466	25 N.J.R. 4496(a)
8:71	Interchangeable drug products	25 N.J.R. 1815(a)	R.1993 d.334	25 N.J.R. 2879(c)
8:71	Interchangeable drug products	25 N.J.R. 2802(b)	R.1993 d.465	25 N.J.R. 4495(b)
8:71	Interchangeable drug products	25 N.J.R. 3906(a)		
8:71	List of Interchangeable Drug Products	25 N.J.R. 4377(a)		
8:71	Interchangeable drug products	25 N.J.R. 4844(a)		
	Most recent update to Title 8: TRANSMITTAL 1993-8 (supplement September 20, 1993)			
HIGHER EDUCATION—TITLE 9				
9:1	Licensing and degree approval standards	25 N.J.R. 3057(a)	R.1993 d.523	25 N.J.R. 4915(a)
9:2-11	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(a)		
9:5-2.1, 2.2, 2.3, 2.5, 2.7	Job training program: unemployed persons tuition waiver	25 N.J.R. 3593(a)		
9:7-9	Paul Douglas Teacher Scholarship Program	25 N.J.R. 3594(a)		
9:11-1.1, 1.2, 1.4, 1.6, 1.10, 1.22, 1.23	Educational Opportunity Fund: student eligibility for undergraduate grants	25 N.J.R. 1663(a)	R.1993 d.480	25 N.J.R. 4596(a)
9:11-1.4	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	25 N.J.R. 4886(a)		
9:11-1.5	Educational Opportunity Fund Program: financial eligibility for undergraduate grants	25 N.J.R. 1946(a)	R.1993 d.479	25 N.J.R. 4597(a)
9:17	Implementing the Higher Education Equipment Leasing Fund	25 N.J.R. 4887(a)		
	Most recent update to Title 9: TRANSMITTAL 1993-6 (supplement September 20, 1993)			
HUMAN SERVICES—TITLE 10				
10:3	Contract administration	25 N.J.R. 3694(b)	R.1993 d.597	25 N.J.R. 5165(a)
10:4	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1323(b)		
10:8	Patient advance directives; DNR orders; declaration of death	25 N.J.R. 2669(a)		
10:31-1.4, 2.1, 2.2, 2.3, 8.1, 9.1	Screening and Screening Outreach Programs: mental health services	25 N.J.R. 1324(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
10:37-5.37–5.43	Repeal (see 10:37A)	25 N.J.R. 2672(a)		
10:37A	Community residences for mentally ill adults	25 N.J.R. 2672(a)		
10:37B	Psychiatric community residences for youth	25 N.J.R. 2197(a)		
10:37C	Community mental health clinical case management	25 N.J.R. 4845(a)		
10:38-1.4, 2.1, 2.2, 3.3, 3.4, 3.6, 3.8, 4.3, 5.2, 7.2, 7.4, 7.5, App. C, E, G	Interim Assistance Program for discharged State psychiatric hospital clients	25 N.J.R. 3697(a)		
10:39	Repeal (see 10:37A)	25 N.J.R. 2672(a)		
10:44A	Licensed community residences to developmentally disabled	25 N.J.R. 4378(a)		
10:49-19.1, 19.4, 19.7, 19.11	State-defined HMOs	Emergency (expires 12-3-93)	R.1993 d.525	25 N.J.R. 4793(a)
10:51-5.6	Pharmaceutical services: income eligibility limits	25 N.J.R. 3407(a)		
10:52-1.9, 1.13	Reimbursement methodology for distinct units in acute care hospitals and for private psychiatric hospitals	24 N.J.R. 4477(a)		
10:52-1.23	Inpatient hospital services: adjustments to Medicaid payer factors	24 N.J.R. 4478(a)		
10:53-1.1	Reimbursement methodology for special hospitals	24 N.J.R. 4477(a)		
10:60-1.1–1.17, 2.2, 2.4, 2.5, 2.8, 2.9, 2.10, 2.12, 2.14, 2.15, 2.16, 3.2, 3.3, 3.6, 4.2, 6, App. A, H	Home Care Services Manual	25 N.J.R. 2803(a)	R.1993 d.588	25 N.J.R. 5167(a)
10:62	Vision care services	25 N.J.R. 3907(a)		
10:66	Independent clinic services: Medicaid program services	25 N.J.R. 4379(a)		
10:69-5.1	HAAAD income eligibility limits	25 N.J.R. 3407(a)		
10:69A-1.2, 6.2	PAAD income eligibility limits	25 N.J.R. 3407(a)		
10:69B	Lifeline Programs	25 N.J.R. 3701(a)	R.1993 d.586	25 N.J.R. 5167(b)
10:69B-4.2	Lifeline programs: income eligibility limits	25 N.J.R. 3407(a)		
10:80	Organization of the Division of Family Development	Exempt	R.1993 d.518	25 N.J.R. 4931(a)
10:81-2.2, 2.3, 5.1, 7.40-7.47, 15	Fraudulent receipt of AFDC assistance; disqualification penalties	25 N.J.R. 3408(a)		
10:81-8.22	Medicaid eligibility of dependent child of adolescent parent	25 N.J.R. 2815(a)	R.1993 d.519	25 N.J.R. 4931(b)
10:81-10.7, 10.8	Refugee Resettlement Program: eligibility limitations	25 N.J.R. 3919(a)		
10:81-11.4, 11.16A, 11.20	Public Assistance Manual: closing criteria for IV-D cases; application fee for non-AFDC applicants	25 N.J.R. 881(a)		
10:81-11.7, 11.9	Non-AFDC child support orders	25 N.J.R. 2816(a)		
10:81-11.21	Review and adjustment of child support orders in AFDC, foster care, and Medicaid Only cases	25 N.J.R. 2818(a)		
10:81-14.18A	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:82-3.2	Assistance Standards Handbook: administrative correction regarding exempt resources	————	————	25 N.J.R. 4597(b)
10:82-3.14	Deeming income of parents or guardians of adolescent parent	25 N.J.R. 2819(a)	R.1993 d.566	25 N.J.R. 5168(a)
10:82-5.3	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:84	Administration of public assistance programs: agency action on public hearing	24 N.J.R. 4480(a)		
10:84-1	Administration of public assistance programs	24 N.J.R. 4480(b)		
10:86-10.2, 10.6	Child care services: payment rates and co-payment fees	25 N.J.R. 1692(a)		
10:87	Food Stamp Program	25 N.J.R. 4697(b)		
10:97-1.3, 3.1	Commission for the Blind and Visually Impaired: licensing procedure for Business Enterprise Program	25 N.J.R. 4551(d)		
10:121A-5.10	Requirements for adoption agencies: searches	25 N.J.R. 3415(a)	R.1993 d.532	25 N.J.R. 4932(a)
10:123-3.4	Personal needs allowance for eligible residents of residential health care facilities and boarding houses	25 N.J.R. 2684(a)	R.1993 d.489	25 N.J.R. 4598(a)
10:126	Family day care registration: manual of requirements	25 N.J.R. 3703(a)	R.1993 d.533	25 N.J.R. 4932(b)
10:127-2.1, 3.7, 3.8, 5.2, 8.1, 8.4, 9.1, 9.10, 10.4, 10.13, 10.15, 10.16, 10.25	Residential child care facilities requirements: administrative correction	————	————	25 N.J.R. 4932(c)
10:133C-4	Division of Youth and Family Services: case goals	25 N.J.R. 1947(a)	R.1993 d.490	25 N.J.R. 4598(b)
10:133D-2	DYFS case management: case plan	25 N.J.R. 2209(a)	R.1993 d.534	25 N.J.R. 4934(a)
10:133D-4	DYFS case management: in-person visits with clients and substitute care providers	25 N.J.R. 2210(a)	R.1993 d.587	25 N.J.R. 5168(b)
10:140	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(a)		

Most recent update to Title 10: TRANSMITTAL 1993-8 (supplement September 20, 1993)

CORRECTIONS—TITLE 10A

10A:1-1.3, 1.4	Public information requests; reimbursement for copying costs	25 N.J.R. 4552(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
10A:1-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1326(b)		
10A:2-2.2	Inmate accounts: transaction fees	25 N.J.R. 4849(a)		
10A:3-1.4, 2.3	Inmate keep separate status	25 N.J.R. 4702(a)		
10A:4-4.1	Inmate discipline: sexual assault	25 N.J.R. 3416(a)	R.1993 d.488	25 N.J.R. 4599(a)
10A:4-5.1, 5.2, 5.3	Sanctions for prohibited acts committed by inmates	25 N.J.R. 4435(a)	R.1993 d.584	25 N.J.R. 5169(a)
10A:9-5.5	Restoration to inmates of forfeited commutation credits	25 N.J.R. 4553(a)		
10A:16-9.1	Blood donation by inmates: autologous donations	25 N.J.R. 3920(a)	R.1993 d.567	25 N.J.R. 5170(a)
10A:31-6.13	Reimbursement for copy costs	25 N.J.R. 4552(a)		
10A:71-3.21	State Parole Board: future parole eligibility terms	25 N.J.R. 4703(a)		
10A:71-3.47	State Parole Board: victim input	25 N.J.R. 4705(a)		
10A:71-7.16	State Parole Board: general conditions of parole and future eligibility upon revocation	25 N.J.R. 3597(a)		
	Most recent update to Title 10A: TRANSMITTAL 1993-5 (supplement September 20, 1993)			
INSURANCE—TITLE 11				
11:1-3	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1327(a)		
11:1-7	New Jersey Property-Liability Insurance Guaranty Association: plan of operation	25 N.J.R. 1045(a)		
11:1-31	Surplus lines insurer eligibility	25 N.J.R. 1819(a)		
11:1-32.4, 35	Insurance holding company systems	25 N.J.R. 4275(a)	R.1993 d.554	25 N.J.R. 5170(b)
11:1-34	Surplus lines: exportable list procedures	24 N.J.R. 4331(a)		
11:1-36	Examination of insurers	25 N.J.R. 4284(a)	R.1993 d.555	25 N.J.R. 5180(a)
11:2-17.11	Payment of third-party claims: written notice by insurer to claimant	25 N.J.R. 3921(a)		
11:2-27	Determination of insurers in a hazardous financial condition	25 N.J.R. 4286(a)	R.1993 d.556	25 N.J.R. 5182(a)
11:2-28	Credit for reinsurance	25 N.J.R. 4289(a)	R.1993 d.557	25 N.J.R. 5184(a)
11:2-34	Surplus lines: allocation of premium tax and surcharge	25 N.J.R. 1826(a)	R.1993 d.582	25 N.J.R. 5194(a)
11:2-36	Risk retention groups and purchasing groups	25 N.J.R. 4298(a)	R.1993 d.558	25 N.J.R. 5197(a)
11:2-37	Producer-controlled insurers	25 N.J.R. 4304(a)	R.1993 d.559	25 N.J.R. 5202(a)
11:2-38	Increase in property and casualty capital and surplus requirements	25 N.J.R. 4306(a)	R.1993 d.560	25 N.J.R. 5204(a)
11:2-39	Increase in capital and surplus requirements for life and health insurers	25 N.J.R. 4309(a)	R.1993 d.561	25 N.J.R. 5208(a)
11:2-40	Life, health and annuity reinsurance agreements	25 N.J.R. 4314(a)	R.1993 d.562	25 N.J.R. 5212(a)
11:3-2.2, 2.4, 2.5, 2.6, 2.11, 2.12	Personal Automobile Insurance Plan	25 N.J.R. 2212(a)	R.1993 d.548	25 N.J.R. 5215(a)
11:3-3	Limited assignment distribution servicing carriers	25 N.J.R. 1327(b)		
11:3-16.7	Automobile insurance: rating programs for physical damage coverages	24 N.J.R. 3604(a)	Expired	
11:3-16.10	Private passenger automobile insurance: rate filing requirements	25 N.J.R. 4436(a)		
11:3-20.5, 20A.1	Automobile insurers: reporting apportioned share of MTF losses in excess profits reports; ratio limiting the effect of negative excess investment income	25 N.J.R. 1829(a)		
11:3-28.1, 28.2, 28.4, 28.6, 28.10-28.13, App. A, B	Reimbursement of excess medical expense benefits paid by automobile insurers	25 N.J.R. 2636(b)	R.1993 d.583	25 N.J.R. 5219(a)
11:3-29.2, 37.10	Automobile insurance PIP coverage: application of medical fee schedules to acute care hospitals and other facilities	25 N.J.R. 4706(a)		
11:3-29.6	Personal auto injury fee schedule: physician's services	25 N.J.R. 4554(a)		
11:3-42.2, 42.9	Producer Assignment Program: request for exemption	25 N.J.R. 2215(a)		
11:4-37	Selective contracting arrangements of insurers	25 N.J.R. 4554(b)		
11:5	Real Estate Commission rules	25 N.J.R. 3597(b)	R.1993 d.552	25 N.J.R. 5229(a)
11:5-1.3	Real Estate Commission: broker pre-licensure requirements	25 N.J.R. 4849(b)		
11:5-1.9	Real Estate Commission: transmittal of funds to lenders	24 N.J.R. 4268(a)		
11:5-1.10	Real Estate Commission: compensation and licensure requirement	25 N.J.R. 4851(a)		
11:5-1.27	Real Estate Commission: educational requirements for broker and salesperson licensure	25 N.J.R. 4852(a)		
11:5-1.28	Real Estate Commission: licensure requirements for schools and instructors	25 N.J.R. 4855(a)		
11:5-1.31	Real Estate Commission: license transfer procedure	25 N.J.R. 4858(a)		
11:5-1.43	Real Estate Commission: licensee provision of Agency Information Statement	25 N.J.R. 1948(a)		
11:5-1.43	Real Estate Commission: extension of comment period regarding licensee provision of Agency Information Statement	25 N.J.R. 2645(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
11:13-7.4, 7.5	Commercial lines: exclusions from coverage; refiling policy forms	25 N.J.R. 1053(a)		
11:16-1.2	Statement of liability for fraud on claim forms: administrative correction	———	———	25 N.J.R. 5229(b)
11:17-1.2, 2.3–2.15, 5.1–5.6	Insurance producer licensing	24 N.J.R. 3216(a)	R.1993 d.507	25 N.J.R. 4744(b)
11:17-6	Managing general agents	25 N.J.R. 4318(a)	R.1993 d.563	25 N.J.R. 5229(c)
11:17-7	Reinsurance intermediaries	25 N.J.R. 4323(a)	R.1993 d.564	25 N.J.R. 5234(a)
11:19-2.2, 2.3, 2.5, App. B	Data submission requirements for all domestic insurers	25 N.J.R. 2820(b)		
11:20-2	Individual Health Coverage Program: temporary plan of operation	25 N.J.R. 4707(a)	R.1993 d.550	25 N.J.R. 5244(a)
11:20-11	Individual Health Insurance Reform Act: relief from obligations	25 N.J.R. 4559(a)		
11:21	Small Employer Health Benefits Program	25 N.J.R. 3599(a)	R.1993 d.553	25 N.J.R. 5253(a)
11:21-1.3, 1.4, 1.5, 6, 7, 7A, 17, 18, App. Exh. N–T	Small Employer Health Benefits Program	25 N.J.R. 4437(a)		
11:21-2	Small Employer Health Benefits Program: Plan of Operation	25 N.J.R. 4563(a)		
11:21-2	Small Employer Health Benefits Program: public hearing on Plan of Operation	25 N.J.R. 4678(a)		
11:21-14	Small Employer Health Benefits Program: declaration and approval of reinsuring or risk-assuming carrier status	25 N.J.R. 4572(a)	R.1993 d.551	25 N.J.R. 5347(a)
11:21-15	Small Employer Health Benefits Program: relief from obligations	25 N.J.R. 4577(a)		
11:21-16	Small Employer Health Benefits Program: withdrawal of carriers from plans market	25 N.J.R. 4859(a)		
11:21–App. Exh. E	Small Employer Health Benefits Program: correction to proposed Appendix Exhibit E and extension of comment period	25 N.J.R. 4458(a)		

Most recent update to Title 11: TRANSMITTAL 1993-9 (supplement September 20, 1993)

LABOR—TITLE 12				
12:3-1	Debarment from contracting with Department	25 N.J.R. 4716(a)		
12:5	Department audit resolution procedures	25 N.J.R. 3417(a)	R.1993 d.511	25 N.J.R. 4748(a)
12:6	Petitions for rulemaking	25 N.J.R. 3682(a)	R.1993 d.512	25 N.J.R. 4748(b)
12:7	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1334(a)		
12:7	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA): extension of comment period	25 N.J.R. 2216(a)		
12:15-1.3, 1.4, 1.5, 1.6, 1.7	Unemployment Compensation and Temporary Disability: 1994 maximum benefit rates, taxable wage base, government entity contribution rate, base week, and alternative earnings test	25 N.J.R. 3922(a)	R.1993 d.589	25 N.J.R. 5351(a)
12:17-11.2	Offset of unemployment benefits by retirement and pension income	25 N.J.R. 3923(a)	R.1993 d.590	25 N.J.R. 5352(a)
12:18-1.1, 2.4, 2.27, 2.40, 2.43, 2.48, 3.1, 3.2, 3.3	Temporary Disability Benefits Program	25 N.J.R. 1515(c)		
12:23	Workforce Development Partnership Program: application and review process for customized training services	25 N.J.R. 449(a)		
12:23-3	Workforce Development Partnership Program: application and review process for individual training grants	25 N.J.R. 884(a)		
12:23-4	Workforce Development Partnership Program: application and review process for approved training	25 N.J.R. 886(a)		
12:23-5	Workforce Development Partnership Program: application and review process for additional unemployment benefits during training	25 N.J.R. 887(a)		
12:23-6	Workforce Development Partnership Program: application and review process for employment and training grants for services to disadvantaged workers	25 N.J.R. 1054(a)		
12:45	Vocational Rehabilitation Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2216(b)		
12:175	Ski lift safety	25 N.J.R. 4581(a)		
12:235-1.6	Workers' Compensation: 1994 maximum benefit rate	25 N.J.R. 3925(a)	R.1993 d.591	25 N.J.R. 5352(b)

Most recent update to Title 12: TRANSMITTAL 1993-8 (supplement September 20, 1993)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
COMMERCE AND ECONOMIC DEVELOPMENT—TITLE 12A				
12A:1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1335(b)		
12A:10-1	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		
12A:10-2	Minority and female contractor and subcontractor participation in State construction contracts	25 N..R. 4461(b)		
12A:11-1.2, 1.3, 1.4, 1.7	Certification of women-owned and minority-owned businesses: extension of comment period	25 N.J.R. 2216(c)		
12A:11-1.2, 1.3, 1.4, 1.7	Certification of women-owned and minority-owned businesses	25 N.J.R. 2484(a)		
12A:121	Urban Enterprise Zone Authority: policies	25 N.J.R. 4582(a)		
	Most recent update to Title 12A: TRANSMITTAL 1993-4 (supplement August 16, 1993)			
LAW AND PUBLIC SAFETY—TITLE 13				
13:1C	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1338(a)		
13:18-6.1, 6.2	Division of Motor Vehicles: insurance verification	25 N.J.R. 3925(b)		
13:19-10.1	Operating motorcycle or motorized bicycle without protective helmet	25 N.J.R. 2646(a)	R.1993 d.486	25 N.J.R. 4599(b)
13:20-37	Motor vehicles with modified chassis height	24 N.J.R. 3662(a)	Expired	
13:20-43	Enhanced motor vehicle inspection and maintenance program: pre-proposal	25 N.J.R. 3418(a)		
13:27-5.8	Board of Architects: examination fees	25 N.J.R. 3704(a)		
13:29-1.13	Board of Accountancy: biennial renewal fee for inactive or retired licensees	25 N.J.R. 1665(b)	R.1993 d.585	25 N.J.R. 5352(c)
13:30-1.1	Board of Dentistry: qualifications of applicants for licensure to practice	25 N.J.R. 2216(d)		
13:30-8.1	Board of Dentistry: fee schedules	25 N.J.R. 3927(a)	R.1993 d.598	25 N.J.R. 5352(d)
13:30-8.6	Board of Dentistry: professional advertising	25 N.J.R. 2823(a)		
13:30-8.7	Board of Dentistry: patient records	25 N.J.R. 1833(a)		
13:33-1.35, 1.36	Ophthalmic dispensers and technicians: referrals; space rental agreements	24 N.J.R. 4010(a)		
13:34	Board of Marriage Counselor Examiners rules	25 N.J.R. 3060(a)		
13:35-2A.9, 2A.11, 6.13	Certified midwife practice: prescriptive authority	25 N.J.R. 4583(a)		
13:35-6.5	Board of Medical Examiners: permissible charges for copies of patient records	25 N.J.R. 4862(a)		
13:35-6.10	Board of Medical Examiners: request for comment regarding advertising of specialty certification	25 N.J.R. 2824(a)		
13:35-6.18	Board of Medical Examiners: control of anabolic steroids	24 N.J.R. 4012(a)		
13:35-10	Practice of athletic trainers	25 N.J.R. 265(a)	R.1993 d.546	25 N.J.R. 4935(a)
13:35-11	Board of Medical Examiners: Alternative Resolution Program	25 N.J.R. 2824(b)		
13:37	Board of Nursing rules	25 N.J.R. 455(b)		
13:37-7	Certification of nurse practitioners/clinical nurse specialists	25 N.J.R. 2829(a)		
13:37-12.1	Board of Nursing: fee schedule	25 N.J.R. 3928(a)		
13:37-12.1, 14	Board of Nursing: certification of homemaker-home health aides	25 N.J.R. 1950(a)		
13:37-14	Homemaker-home health aide competency evaluation: public hearing	25 N.J.R. 3704(b)		
13:39-5.2	Board of Pharmacy: information on prescription labels	25 N.J.R. 1667(a)		
13:39A-2.5	Board of Physical Therapy: referral of patients from chiropractors	25 N.J.R. 3938(a)		
13:40A-3.5, 6.1	Board of Real Estate Appraisers: fees; temporary licenses	25 N.J.R. 4863(a)		
13:41-2.1	Board of Professional Planners: professional misconduct	24 N.J.R. 3221(a)	R.1993 d.506	25 N.J.R. 4748(c)
13:42	Board of Psychological Examiners rules	25 N.J.R. 3062(a)	R.1993 d.547	25 N.J.R. 4937(a)
13:42	Board of Psychological Examiners rules: public hearing and extension of comment period regarding psychoanalysis and scope of practice, and employment by non-profit community organization	25 N.J.R. 4585(a)		
13:42-1.2	Board of Psychological Examiners: written examination fee	25 N.J.R. 3929(a)		
13:42-1.2, 1.3	Board of Psychological Examiners rules	25 N.J.R. 4937(a)		
13:44-1.2, 1.3, 1.4, 2.9	Board of Veterinary Medical Examiners: examinations	25 N.J.R. 3930(a)		
13:44D-2.4	Advisory Board of Public Movers and Warehousemen: late renewal and reinstatement fee timeframes	25 N.J.R. 3931(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
13:44E-1.1	Board of Chiropractic Examiners: scope of chiropractic practice	25 N.J.R. 3931(b)		
13:44E-2.1	Board of Chiropractic Examiners: licensee advertising	25 N.J.R. 3932(a)		
13:44E-2.6	Board of Chiropractic Examiners: practice identification educational requirements	25 N.J.R. 3934(a)		
13:44E-2.8	Board of Chiropractic Examiners: duties of unlicensed assistants	25 N.J.R. 3935(a)		
13:44E-2.9	Board of Chiropractic Examiners: notification of change of address; service of process	25 N.J.R. 3936(a)		
13:44E-2.10, 2.11	Board of Chiropractic Examiners: display of license; right to licensure hearing	25 N.J.R. 3936(b)		
13:44E-2.13	Board of Chiropractic Examiners: overutilization of services; excessive fees	25 N.J.R. 3937(a)		
13:44E-2.14	Board of Chiropractic Examiners: referral of patients to physical therapists	25 N.J.R. 3938(a)		
13:44G-1–5, 7, 8	Board of Social Work Examiners rules	25 N.J.R. 3081(a)		
13:45A-12.3	Sale of animals: administrative correction	_____	_____	25 N.J.R. 4600(a)
13:45A-21, 22	Kosher Enforcement Bureau: sale of food represented as kosher	25 N.J.R. 3086(a)		
13:45A-26	Automotive dispute resolution	25 N.J.R. 3939(a)		
13:46-2	Athletic Control Board: participant health and safety in boxing and combative sports events	25 N.J.R. 4717(a)		
13:70-1.31	Thoroughbred racing: prohibited services by Racing Commission employees and appointees	25 N.J.R. 4458(b)		
13:70-3.40	Thoroughbred racing: minimum age for admittance to racetrack	25 N.J.R. 2647(a)	R.1993 d.483	25 N.J.R. 4600(b)
13:70-12.4	Thoroughbred racing: claimed horse	25 N.J.R. 1059(a)		
13:70-14A.1	Thoroughbred racing: intent of medication rules	25 N.J.R. 3099(a)		
13:70-14A.9	Thoroughbred racing: administering medication to respiratory bleeders	25 N.J.R. 3100(a)		
13:70-20.11	Thoroughbred racing: limitations on entering or starting	25 N.J.R. 3101(a)		
13:70-21.4	Thoroughbred racing: medication	25 N.J.R. 3102(a)		
13:70-29.52	Thoroughbred racing: Pick(N)	25 N.J.R. 4585(b)		
13:70-29.53	Thoroughbred racing: trifecta	25 N.J.R. 3103(a)	R.1993 d.516	25 N.J.R. 4751(a)
13:71-1.26	Harness racing: prohibited services by Racing Commission employees and appointees	25 N.J.R. 4459(a)		
13:71-2.3	Harness racing: suspension from driving	25 N.J.R. 2647(b)	R.1993 d.484	25 N.J.R. 4600(c)
13:71-5.18	Harness racing: minimum age for admittance to racetrack	25 N.J.R. 2648(a)	R.1993 d.485	25 N.J.R. 4600(d)
13:71-23.1	Harness racing: intent of medication rules	25 N.J.R. 3104(a)		
13:71-23.3B, 23.3C	Harness racing: pre-race blood gas analyzing machine testing program	25 N.J.R. 3427(a)	R.1993 d.513	25 N.J.R. 4751(b)
13:71-23.8	Harness racing: administering medication to respiratory bleeders	25 N.J.R. 3105(a)		
13:71-27.50	Harness racing: trifecta	25 N.J.R. 3106(a)	R.1993 d.515	25 N.J.R. 4752(a)
13:71-27.56	Harness racing: the Pick(N)	25 N.J.R. 3705(a)	R.1993 d.514	25 N.J.R. 4752(b)
13:78	Administration of Victim and Witness Advocacy Fund	25 N.J.R. 4721(a)		
13:79	Safe and Secure Communities Program	25 N.J.R. 4511(a)	R.1993 d.596	25 N.J.R. 5353(a)
	Most recent update to Title 13: TRANSMITTAL 1993-9 (supplement September 20, 1993)			
PUBLIC UTILITIES (BOARD OF REGULATORY COMMISSIONERS)—TITLE 14				
14:0	IntraLATA competition for telecommunications services: preproposal	25 N.J.R. 3682(b)		
14:0	Intrastate dial-around compensation: preproposal	25 N.J.R. 4586(a)		
14:3-3.6	Discontinuance of service to multi-family dwellings	25 N.J.R. 1346(a)		
14:3-10.15	Solid waste collection: customer lists	24 N.J.R. 3286(c)	R.1993 d.508	25 N.J.R. 4763(a)
14:11-7.10	Solid waste disposal facilities: initial tariff for special in lieu payment	24 N.J.R. 3286(c)	R.1993 d.508	25 N.J.R. 4763(a)
14:18-2.11	Cable television: pre-proposal regarding disposition of on-premises wiring	24 N.J.R. 4496(a)		
14:18-2.11	Cable television: change in hearing date and comment period for pre-proposal regarding disposition of on-premises wiring	25 N.J.R. 270(a)		
14:18-10.5	Cable television: performance monitoring	25 N.J.R. 2700(a)		
	Most recent update to Title 14: TRANSMITTAL 1993-5 (supplement September 20, 1993)			
ENERGY—TITLE 14A				
	Most recent update to Title 14A: TRANSMITTAL 1993-1 (supplement February 16, 1993)			
STATE—TITLE 15				
15:1	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1347(a)		
15:10-8	Certification of electronic voting systems	25 N.J.R. 4587(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
15:10-8	Certification of electronic voting systems: public hearing and extension of comment period	25 N.J.R. 4864(a)		

Most recent update to Title 15: TRANSMITTAL 1993-2 (supplement May 17, 1993)

PUBLIC ADVOCATE—TITLE 15A

Most recent update to Title 15A: TRANSMITTAL 1990-3 (supplement August 20, 1990)

TRANSPORTATION—TITLE 16

16:1B	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1478(a)		
16:28-1.6, 1.56, 1.111	Speed limit zones along U.S. 40, U.S. 40 and 322, and Route 87 in Atlantic County	25 N.J.R. 3942(a)	R.1993 d.574	25 N.J.R. 5356(a)
16:28-1.125	Speed limits along Route 67 in Fort Lee	25 N.J.R. 3442(a)	R.1993 d.500	25 N.J.R. 4601(a)
16:28A-1.2, 1.31, 1.36, 1.44	Parking restrictions along U.S. 1 and 9 in Elizabeth, Route 45 in Woodbury, Route 57 in Washington Borough, Route 88 in Lakewood and Brick Township	25 N.J.R. 3443(a)	R.1993 d.499	25 N.J.R. 4601(b)
16:28A-1.9, 1.18, 1.19, 1.37	Parking restrictions along Route 17 in Paramus, Route 27 in Rahway, Route 28 in Bound Brook, and Route 70 in Manchester	25 N.J.R. 4725(a)		
16:28A-1.19	Parking restrictions along Route 28 in Bound Brook	25 N.J.R. 3943(a)	R.1993 d.575	25 N.J.R. 5356(b)
16:28A-1.19, 1.57	Parking restrictions along Route 28 in Bound Brook and U.S. 206 in Hamilton Township	25 N.J.R. 4459(b)		
16:28A-1.20, 1.25, 1.31, 1.41	Restricted parking and stopping along Route 29 in Lambertville, Route 35 in Berkeley Township, Route 45 in Woodbury, and Route 77 in Bridgeton	25 N.J.R. 3127(a)	R.1993 d.501	25 N.J.R. 4602(a)
16:28A-1.41	Time limit parking on Route 77 in Bridgeton: correction to proposal	25 N.J.R. 3944(a)		
16:28A-1.41	Restricted parking along Route 77 in Bridgeton	25 N.J.R. 3944(b)	R.1993 d.576	25 N.J.R. 5357(a)
16:28A-1.41	Time limit parking in Bridgeton	25 N.J.R. 4118(a)	R.1993 d.577	25 N.J.R. 5358(a)
16:30-6.1	Weight limit on Edison Bridge along U.S. 9 over Raritan River	25 N.J.R. 3863(a)	R.1993 d.578	25 N.J.R. 5358(b)
16:30-10.15	Midblock crosswalk along Route 27 in Franklin Township and North Brunswick	25 N.J.R. 3128(a)	R.1993 d.502	25 N.J.R. 4603(a)
16:30-10.16	Midblock crosswalk on Route 71 in Belmar	25 N.J.R. 3683(a)	R.1993 d.579	25 N.J.R. 5359(a)
16:31-1.10	Left turn prohibition along U.S. 30 in Magnolia Borough	25 N.J.R. 3445(a)	R.1993 d.503	25 N.J.R. 4603(b)
16:31-1.32	U turn prohibition along Route 36 in Sea Bright	25 N.J.R. 4460(b)		
16:31-1.33	U turn prohibition along Route 12 in Flemington and Raritan Township	25 N.J.R. 4460(a)		
16:41D	Motorist service signs on non-urban interstate and limited access highways	25 N.J.R. 2836(a)		
16:44	Construction services	25 N.J.R. 1954(a)		
16:44	Construction Services: waiver of sunset provision of Executive Order No. 66(1978)	25 N.J.R. 2227(a)		
16:44	Construction services	25 N.J.R. 4727(a)		
16:47-1.1, 4.1, 4.3–4.6, 4.13, 4.32, 4.35, App. B	State Highway Access Management Code	25 N.J.R. 3129(a)	R.1993 d.524	25 N.J.R. 4915(a)
16:47-8.5	State Highway Access Management Code: access classifications	25 N.J.R. 3945(a)		
16:50	Employer Trip Reduction Program (ETRP)	25 N.J.R. 3132(a)		
16:53D-1.1	Zone of rate freedom for regular route private autobus carriers: 1994 percentage maximum	25 N.J.R. 3684(a)	R.1993 d.537	25 N.J.R. 4918(a)
16:80	NJ TRANSIT: Section 16(b)(2) Capital Assistance Program	25 N.J.R. 3142(a)	R.1993 d.527	25 N.J.R. 4918(b)
16:81	NJ TRANSIT: Small Urban and Rural Area Public Transportation Program	25 N.J.R. 3144(a)	R.1993 d.528	25 N.J.R. 4920(a)
16:84	NJ TRANSIT: disability discrimination complaint procedure	25 N.J.R. 3445(b)	R.1993 d.530	25 N.J.R. 4921(a)
16:85	NJ TRANSIT: contracting policies and procedures	25 N.J.R. 3450(a)	R.1993 d.529	25 N.J.R. 4925(a)

Most recent update to Title 16: TRANSMITTAL 1993-9 (supplement September 20, 1993)

TREASURY-GENERAL—TITLE 17

17:3	Teachers' Pension and Annuity Fund	25 N.J.R. 4461(a)		
17:6	Consolidated Police and Firemen's Pension Fund	25 N.J.R. 3946(a)		
17:13	Goods and services contracts for small businesses, minority businesses, and female businesses	25 N.J.R. 4889(a)		
17:14	Minority and female contractor and subcontractor participation in State construction contracts	25 N.J.R. 4461(b)		
17:27	Affirmative action rules	25 N.J.R. 3706(a)	R.1993 d.531	25 N.J.R. 4927(a)

Most recent update to Title 17: TRANSMITTAL 1993-9 (supplement September 20, 1993)

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
TREASURY-TAXATION—TITLE 18				
18:2	Division of Taxation policies and procedures	25 N.J.R. 3107(a)	R.1993 d.542	25 N.J.R. 4927(b)
18:2-3	Payment of taxes by electronic funds transfer	25 N.J.R. 1078(a)		
18:7-13.8	Corporation Business Tax: claims for refund	25 N.J.R. 1842(a)		
18:12	Local property tax rules: preparation of tax lists; revaluation; appeals; homestead rebate; exemptions	25 N.J.R. 2652(a)	R.1993 d.482	25 N.J.R. 4604(a)
18:12-4.5	Local property tax assessors: conflict of interest	25 N.J.R. 4591(a)		
18:12-10.1, 10.2, 10.3	Local property tax: classification of real and personal property	25 N.J.R. 61(a)	R.1993 d.504	25 N.J.R. 4792(a)
18:12A-1.18	Local property tax assessors: conflict of interest	25 N.J.R. 4591(a)		
18:12A-18:17	Local property taxation: county boards; senior citizens' deduction; farmland assessment; realty transfer fee; assessor qualification	25 N.J.R. 2653(a)	R.1993 d.481	25 N.J.R. 4604(b)
18:35-1.14, 1.25	Gross Income Tax: partnerships; net profits from business	25 N.J.R. 677(a)		
18:35-1.17	Gross income tax: Health Care Subsidy Fund withholding	25 N.J.R. 1957(a)		
	Most recent update to Title 18: TRANSMITTAL 1993-4 (supplement July 19, 1993)			
TITLE 19—OTHER AGENCIES				
19:3A-3	HMDC: Disability discrimination grievance procedure	25 N.J.R. 3946(b)		
19:4-2.2, 4.23A, 4.30, 4.39, 4.49, 4.59, 4.69, 4.88, 4.98, 4.107, 4.117, 4.129, 4.152	HMDC: District zoning rules	25 N.J.R. 3949(a)		
19:4-6.28	Official Zoning Map: rezoning of site in Kearny	25 N.J.R. 3429(a)		
19:4A-3.1, 4.4, 5.3, 5.7, 6.2	HMDC: District zoning rules	25 N.J.R. 3949(a)		
19:9	Turnpike Authority rules	25 N.J.R. 2839(b)	R.1993 d.496	25 N.J.R. 4605(a)
19:9	Turnpike Authority rules: extension of comment period	25 N.J.R. 3685(a)		
19:9	Turnpike Authority rules: administrative correction	_____	_____	25 N.J.R. 4927(c)
19:25	ELEC: Establishment of committees; reporting requirements	25 N.J.R. 3429(b)	R.1993 d.509	25 N.J.R. 4753(a)
19:30-7	Economic Development Authority: Disability discrimination complaint procedure	25 N.J.R. 4864(b)		
19:31-8	Economic Development Authority: Hazardous Discharge Site Remediation Fund	25 N.J.R. 4468(a)		
19:75	South Jersey Transportation Authority: rules of operation	25 N.J.R. 4874(a)		
	Most recent update to Title 19: TRANSMITTAL 1993-7 (supplement July 19, 1993)			
TITLE 19 SUBTITLE K—CASINO CONTROL COMMISSION/CASINO REINVESTMENT DEVELOPMENT AUTHORITY				
19:40-1.2, 3.3	Definitions	25 N.J.R. 4866(a)		
19:40-6	Disability discrimination grievance procedure regarding compliance with Americans with Disabilities Act (ADA)	25 N.J.R. 1503(a)		
19:41-5.1, 5.11, 5.12	Vendor Registration Form; Junket Enterprise Registration Form	25 N.J.R. 3951(a)	R.1993 d.571	25 N.J.R. 5359(b)
19:41-7.2A	Applicant identification	25 N.J.R. 4736(a)		
19:41-8.8	Reapplication for employee licensure or registration after denial or revocation	25 N.J.R. 3685(b)	R.1993 d.572	25 N.J.R. 5360(a)
19:42-1.1	Definitions	25 N.J.R. 4866(a)		
19:42-2.2	Motions for reconsideration or relief	25 N.J.R. 3685(b)	R.1993 d.572	25 N.J.R. 5360(a)
19:42-4.5	Exclusion of persons from casino premises	25 N.J.R. 4739(a)		
19:43-9.2	Casino licensee employment requirements: persons denied licensure or with revoked or suspended licensure or registration	25 N.J.R. 4871(a)		
19:43-13.1	Definitions	25 N.J.R. 4866(a)		
19:44-8.3	Poker	25 N.J.R. 2236(a)		
19:45-1.1	Definitions	25 N.J.R. 4866(a)		
19:45-1.1, 1.2, 1.11, 1.12, 1.20	Poker	25 N.J.R. 2236(a)		
19:45-1.1, 1.14A	Casino simulcasting	25 N.J.R. 4737(a)		
19:45-1.1, 1.16, 1.33, 1.36, 1.37, 1.42, 1.44, 1.46, 1.46A, 1.46B	Coupon redemption for slot machine play	25 N.J.R. 4471(a)		
19:45-1.1, 1.34, 1.35, 1.46	Imprest inventory of changepersons	25 N.J.R. 3107(b)	R.1993 d.492	25 N.J.R. 4618(a)
19:45-1.1, 1.40	Jackpot payouts not paid directly from slot machine	25 N.J.R. 2227(b)	R.1993 d.491	25 N.J.R. 4615(a)
19:45-1.9, 1.9B	Complimentary services, items, cash, and noncash gifts	25 N.J.R. 3108(a)	R.1993 d.494	25 N.J.R. 4619(a)
19:45-1.9, 1.9B	Direct mass marketing complimentary programs	25 N.J.R. 4871(b)		
19:45-1.12A	Minimum and maximum gaming wagers	25 N.J.R. 3953(a)		
19:45-1.19	Card-o-lette	25 N.J.R. 2230(a)		

N.J.A.C. CITATION		PROPOSAL NOTICE (N.J.R. CITATION)	DOCUMENT NUMBER	ADOPTION NOTICE (N.J.R. CITATION)
19:45-1.32, 1.43	Court room requirements and procedure	25 N.J.R. 2855(a)	R.1993 d.493	25 N.J.R. 4622(a)
19:45-1.41	Slot machine hopper fills	25 N.J.R. 4474(a)		
19:45-1.42	Unsecured currency in a bill changer	25 N.J.R. 4873(a)		
19:46-1.1, 1.4, 1.5	Gaming chips	25 N.J.R. 3111(a)		
19:46-1.1, 1.8, 1.9, 1.13F, 1.20	Card-o-lette	25 N.J.R. 2230(a)		
19:46-1.5	Imprest inventory of changepersons	25 N.J.R. 3107(b)	R.1993 d.492	25 N.J.R. 4618(a)
19:46-1.12	Minibaccarat: charging vigorish	25 N.J.R. 4474(b)		
19:46-1.13E, 1.17, 1.18	Poker	25 N.J.R. 2236(a)		
19:46-1.20	Gaming equipment: administrative correction	_____	_____	25 N.J.R. 4762(a)
19:46-1.20	Casino simulcasting	25 N.J.R. 4737(a)		
19:46-1.26	Coupon redemption for slot machine play	25 N.J.R. 4471(a)		
19:47	Poker: temporary adoption of new rules	25 N.J.R. 2001(a)		
19:47	Card-o-lette: temporary adoption of new rules	25 N.J.R. 2001(b)		
19:47-1.3, 2.3, 2.6, 3.2, 4.2, 5.1, 5.6, 6.6, 7.2, 8.2, 9.3, 10.10, 11.12, 12.10	Minimum and maximum gaming wagers	25 N.J.R. 3953(a)		
19:47-2	Progressive 21 wager in blackjack: temporary amendments	_____	_____	25 N.J.R. 4927(d)
19:47-7.2, 7.3	Minibaccarat: charging vigorish	25 N.J.R. 4474(b)		
19:47-8.2, 15	Card-o-lette	25 N.J.R. 2230(a)		
19:47-14	Poker	25 N.J.R. 2236(a)		
19:48-1.1, 1.3, 1.4, 1.5, 1.7, 1.8	Exclusion of persons from casino premises	25 N.J.R. 4739(a)		
19:50	Casino hotel alcoholic beverage control	25 N.J.R. 4742(a)		
19:50-1.4, 1.5	Casino hotel alcoholic beverage control: authorized locations	25 N.J.R. 3687(a)	R.1993 d.541	25 N.J.R. 4928(a)
19:50-2.2	CHAB licensee operating conditions	25 N.J.R. 3688(a)	R.1993 d.539	25 N.J.R. 4928(b)
19:50-3.1, 3.6	Alcoholic beverage service in casinos and simulcasting facilities	25 N.J.R. 3689(a)	R.1993 d.540	25 N.J.R. 4929(a)
19:51-1.1	Definitions	25 N.J.R. 4866(a)		
19:51-1.2	Casino simulcasting	25 N.J.R. 4737(a)		
19:51-1.2, 1.8	Casino service industry licensure: regular and continuing business criteria	25 N.J.R. 2662(a)	R.1993 d.495	25 N.J.R. 4625(a)
19:53-1.2, 5.4	Ineligibility of successor business for provisional certification as a women or minority business enterprise	25 N.J.R. 3955(a)	R.1993 d.573	25 N.J.R. 5361(a)
19:53-1.3, 1.5, 2.3, 4.4, 6.2, 6.6	Equal employment and business opportunity	25 N.J.R. 3690(a)	R.1993 d.538	25 N.J.R. 4929(b)
19:54-1.2	Definitions	25 N.J.R. 4866(a)		
19:54-1.6	Computation of gross revenue tax	25 N.J.R. 4475(a)		
19:55-1.1, 2.9, 4.3, 4.10, 6.2, 7.1, 8.1	Casino simulcasting	25 N.J.R. 4737(a)		
19:65-1.2, 2.2, 2.4–2.11, 6.1, 6.2	Hotel development and corridor region projects	25 N.J.R. 4476(a)		
19:65-1.2, 2.4, 2.5, 2.6, 2.10, 2.11	Hotel development project eligibility and conditions	Emergency (expires 10-29-93)	R.1993 d.478	25 N.J.R. 4514(a)

Most recent update to Title 19K: TRANSMITTAL 1993-9 (supplement September 20, 1993)

RULEMAKING IN THIS ISSUE—Continued

PUBLIC NOTICES

EDUCATION
- 1993-94 Edition of Directory of Federal and State Programs: availability of copies ..... 5363(a)
- State Plan for Special Education: continued conditional approval ..... 5363(b)

ENVIRONMENTAL PROTECTION AND ENERGY
- Delaware and Raritan Canal State Park: public hearing regarding proposed exchange of properties ..... 5363(c)
- Northeast Water Quality Management Plan: Bergen County Utilities Authority district and Rochelle Park ..... 5363(d)
- Upper Raritan Water Quality Management Plan: Tewksbury Township WMP ..... 5364(a)
- Statewide Sludge Management Plan Update: second public hearing ..... 5364(b)

HUMAN SERVICES
- Food Stamp Program: income eligibility, deduction, and allotment standards ..... 5365(a)

CORRECTIONS
- Inmate discipline: petition for rulemaking regarding medical/behavioral reports ..... 5365(b)

INSURANCE
- Commercial lines insurance: special risks ..... 5366(a)

TREASURY-TAXATION
- Sanitary landfill taxes: 1994 rates ..... 5366(b)

HIGHWAY AUTHORITY
- Garden State Parkway: petition for rulemaking regarding placement of off-roadway business logos ..... 5367(a)

INDEX OF RULE PROPOSALS AND ADOPTIONS 5368

Filing Deadlines

December 20 issue:
- **Proposals ..... November 17**
- **Adoptions ..... November 24**

January 3, 1994 issue:
- **Proposals ..... December 2**
- **Adoptions ..... December 9**

January 18 issue:
- **Proposals ..... December 15**
- **Adoptions ..... December 22**

NOTES

OFFICE OF ADMINISTRATIVE LAW PUBLICATIONS

NEW JERSEY ADMINISTRATIVE CODE

☐ **FULL SET** (INCLUDES ALL TITLES BELOW) $1655

INDIVIDUAL TITLES

1.	Administrative Law	$ 70
2.	Agriculture	$ 70
3.	Banking	$ 70
4A.	Personnel (formerly Civil Service)	$ 70
5.	Community Affairs (two volumes)	$140
5A.	Military and Veterans' Affairs	$ 70
6.	Education (two volumes)	$140
7.	Environmental Protection (eight volumes; includes NJPDES)	$475
7:14A.	NJPDES Program Rules only	$ 70
8.	Health (four volumes)	$280
9.	Higher Education	$ 70
10.	Human Services (four volumes)	$280
10A.	Corrections	$ 70
11.	Insurance (two volumes)	$140
12.	Labor (two volumes)	$140
12A.	Commerce, Energy and Economic Development	$ 70
13.	Law and Public Safety (four volumes; includes ABC and AGC)	$280
13:2,3.	Alcoholic Beverage Control and Amusement Games Control only	$ 70
14/14A.	Public Utilities/Energy	$ 70
15.	State	$ 70
15A.	Public Advocate	$ 70
16.	Transportation (two volumes)	$140
17.	Treasury-General	$ 70
18.	Treasury-Taxation (two volumes)	$140
19.	Other Agencies: Expressway Authority, Hackensack Meadowlands Commission, Highway Authority, Turnpike Authority, Public Employment Relations Commission, Sports and Exposition Authority, Election Law Enforcement Commission, Economic Development Authority, Public Broadcasting Authority, Executive Commission on Ethical Standards, Atlantic County Transportation Authority, Waterfront Commission of NY Harbor (two volumes)	$140
19K.	Casino Control Commission	$ 70
	Gubernatorial Executive Orders	$ 70
	Full Code Index	$ 70

(Prices include first year of Update Service. Thereafter, Annual Update Service, $40 per volume for all Titles except Title 7, which is $270 for the 8 volumes. Annual Update Service for the Full Set, $780.)

Additional Administrative Code looseleaf binders, $15 each

New Jersey Register (one year, 24 issues)

By second class mail, $125 ☐

By first class mail, $215 ☐

Single copies, $15 each

NEW JERSEY ADMINISTRATIVE REPORTS, 2d

Comprehensive State Agency coverage; administrative law decisions, September 1991 and after. For subscription information and brochure, write or call:

Barclays Law Publishers
File No. 52030
P.O. Box 60000
San Francisco, CA 94160-2030
(800) 888-3600

Prepayment to "OAL Publications" is required for all subscriptions.

Please return form with your payment to:

OAL Publications
9 Quakerbridge Plaza
CN 049
Trenton, New Jersey 08625

Use this form for the Administrative Code, Register, and additional binders, only. To order N.J.A.R. 2d, call 800-888-3600.

Name and Delivery Address:

_____

_____

_____

Billing Address, if different:

_____

_____

_____

Telephone Number _____

Amount Enclosed (specify publications) _____

_____

10/93