

(b) This subchapter shall apply to all carriers that are or become members of the New Jersey Individual Health Coverage Program for any portion of a two-year calculation period for which reports under this subchapter are required to be filed, whether or not the carrier is a member at the time that the report is to be filed.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), deleted "annual" preceding "reporting"; and in (b), substituted "two-year calculation period" for "calendar year".

11:20-8.2 Filing of the market share and net paid gain or (loss) report form

(a) Every member of the IHC Program shall file the report form set forth as Exhibit K in the Appendix to this chapter, on or before March 1, 1999 and on or before March 1 of the year immediately following every two-year calculation period thereafter. Every member shall complete Parts A, B, C and D of the report form, whether or not the member is seeking reimbursements for losses, or exemptions from assessments for losses.

(b) Affiliated carriers shall submit a separate report for each affiliated carrier and a combined report using the report form set forth as Exhibit K in the Appendix.

1. The combined report form shall be submitted under the name of one of the affiliated carrier's members, shall list the affiliated carriers, and shall include as attachments the separate reports of each of the members of the affiliated carrier including the separate report of the member submitted the combined report form, all as one package.

(c) Certified report forms shall be submitted by facsimile to the or mailed or delivered to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Administrative Change.
See: 27 N.J.R. 1423(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), changed the report filing deadlines; and rewrote (b).

11:20-8.3 Net earned premium

(a) Every member shall set forth its net earned premium for the preceding two-year calculation period ending December 31 of the second year in Part C1 of the report.

1. Net earned premium set forth in Part C1 of the report form shall include net earned premium resulting from group health benefits plans and individual health benefits plans issued, continued or renewed during the preceding two-year calculation period, including premiums from conversion health benefits plans.

2. Net earned premium reported in Part C1 of the report form shall be based upon, if not the same as, the data set forth in the member's appropriate NAIC statement blank.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote (a).

11:20-8.4 Calculation of covered non-group persons

Members shall report in Part C2 of the report form the total number of persons covered under individual community rated health benefits plans, conversion health benefits plans, the number of Medicaid recipients covered by the member under a contract with the State of New Jersey, and Medicare lives covered by the member under Medicare cost and risk contracts with the Federal government, as of the last day of each calendar quarter of the preceding two-year calculation period and divide the total of the eight calendar quarters by eight to determine the average non-group enrollment in the preceding two-year calculation period. For contracts issued prior to August 1, 1993, where a member's administrative systems cannot provide the number of actual covered persons, the following factors shall be used to convert contracts or subscribers to the total number of covered persons: single = 1; husband and wife = 2; adult and child(ren) = 2.8; family = 3.9. If a husband and wife category is not used, a member shall use a compromise factor of 3.33 in order to reflect the husband and wife category in the family factor.

Amended by R.1994 d.177, effective March 10, 1994.
See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).
Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.

11:20-8.5 Calculating net paid losses or gains

(a) For purposes for completing Page C3 of the report form, members shall provide data for their individual health benefits plans issued or renewed pursuant to sections 2b(1) or 3 of the Act (N.J.S.A. 17B:27A-3b(1) or 4), for the preceding two-year calculation period.

1. All data shall be for direct business only; reinsurance accepted shall not be included, and reinsurance ceded shall not be deducted.

2. The method used by a member to allocate to sublines of the individual line shall be consistent with the method used by a member to allocate to the individual line.

(b) Premium earned shall be adjusted by any changes in non-admitted premium assets consistent with statutory report requirements, except that any change in non-admitted assets associated with premium accrued shall be reported consistent with the bases, as appropriate to the member, from the member's NAIC annual statement, adjusted for the individual health benefits plan for which the report is being made, as necessary.

(c) In reporting claims paid, profits made by affiliated providers of service shall not be included in paid claims. Claims paid shall be reported on a basis consistent with statutory reporting, as is appropriate for the member based on the member's NAIC annual statement, adjusted as necessary for the individual health benefits plans for which the report is being made.

(d) Net investment income shall be calculated in accordance with statutory reporting requirements. For purposes of Exhibit K reporting, and not withstanding how a carrier allocates net investment income to individual lines in other statutory reports or filings, carriers shall allocate net investment income consistent with the following basis, adjusted for the individual health benefits plans for which the report is being made as necessary.

1. The cost of granting and servicing premium notes and policy loans and liens shall be allocated to investment expense. The resulting net income on premium notes and policy loans and liens may be distributed to those lines of business which produced such income. In making such distribution, due consideration shall be given to the variation in the interest rate and incidence of expense on such notes, loans, and liens.

2. Net investment income, after adjustment, if any, as permitted by (d)1 above, shall be distributed to major and secondary lines of business in proportion to the mean funds of each line of business, after suitable adjustment, if any, on account of policy loans, except that any miscellaneous interest income arising from policy or annuity transactions may be allocated directly to the line of business producing such income. Mean funds refers to the average net cash flow balance over the period for which the calculation is being made. Cash flow is the inception to date paid premium, plus net investment income, plus loss reimbursement received, less paid claims, less refunds, less loss assessment paid, and less paid expenses.

(e) The net paid gain or loss for the two-year calculation period shall be determined by taking the claims paid on individual health benefits (as set forth on line C3b of Exhibit K), less 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans (as set forth in lines C3a and C3c, respectively, of Exhibit K). If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is greater than claims paid on individual health benefits plans, the amount shown of line C3d represents a net paid gain. If 115 percent of the sum of the net earned premium and the net investment income earned on individual health benefits plans is less than claims paid on individual health benefits plans, the amount shown on line C3d represents a net paid loss.

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
Rewrote the section.

11:20-8.6 Certifications

(a) The Chief Financial Officer, or other duly authorized officer of the member, shall certify that all market share and net paid gain (loss) reports filed with the IHC Board are accurate, complete and conform with the requirements of this subchapter. The person certifying the combined market share and net paid gain (loss) report of an affiliated carrier shall be the same person certifying the separate market share and net paid gain (loss) report of the member submitting the combined market share and net paid gain (loss) report for the affiliated carrier. Every duly authorized officer who certifies a separate or combined market share and net paid gain (loss) report shall be responsible for errors contained therein.

(b) The Chief Financial Officer, or other duly authorized officer, of a member which has filed for reimbursement of losses shall certify, on or before March 1 of the year following every two-year calculation period that:

1. The net investment income reported on Exhibit K has been allocated on a basis consistent with N.J.A.C. 11:20-8.5(d) or, if not, the changes have been outlined in detail including the impact and reason for the change.

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "gain" preceding "(loss)" throughout; and rewrote (b).

Case Notes

Health insurer became member of Individual Health Coverage Program subject to assessment for share of program losses upon receiving certificate of authority to operate as health maintenance organization (HMO) in state, regardless of status of its application for approval as federally qualified HMO. Matter of Individual Health Coverage Program Final Administrative Orders Nos. 96-01 and 96-22, 302 N.J.Super. 360, 695 A.2d 371 (N.J.Super.A.D. 1997).

11:20-8.7 Penalties for failure to file market share and net paid loss report

(a) Failure to file in a timely manner market share and net paid gain (loss) reports and certifications required by this subchapter shall result in:

1. The denial of a member's application for exemption from assessments for reimbursable losses; and

2. The Board's using the premium set forth in the member's most recent Annual Statements filed with the Department as the premium base to calculate that member's market share allocation of assessments for reimbursement of losses.

Amended by R.1994 d.177, effective March 10, 1994.

See: 26 N.J.R. 1294(a), 26 N.J.R. 1509(a).

Amended by R.1998 d.443, effective August 7, 1998.

See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

In (a), inserted "gain" preceding "(loss)" in the introductory sentence.

Repeal and New Rule, R.1998 d.443, effective August 7, 1998.
 Sec: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).
 Section was "Exhibit I".

EXHIBIT J
 Loss Ratio Report Form
 New Jersey Individual Health Coverage Program

Reporting Year _____, for the Preceding
 Calendar Year Ending December 31, _____

Name of Carrier: _____ NAIC # _____

Address: _____

Carriers shall complete and file a separate Report Form for each affiliate. Note: Read the corresponding regulation, N.J.A.C. 11:20-7, before you complete this Report.

- A. Net Earned Premium for Standard Health Benefits Plans \$ _____
- B. Total Losses Incurred (1-2-3+4+5+6) = \$ _____
 - 1. Claims paid during the preceding calendar year regardless of the year incurred; \$ _____
 - 2. Residual reserve set on June 30 of the preceding calendar year for claims incurred prior to January 1 of the preceding calendar year; \$ _____
 - 3. Claims paid from January 1 through June 30 of the preceding calendar year for claims incurred prior to January 1 of the of the preceding calendar year as reported in the preceding calendar year's loss ratio report; \$ _____
 - 4. Claims paid from January 1 through June 30 of the reporting year for claims incurred prior to January 1 of the reporting year; \$ _____
 - 5. Residual reserve for claims incurred prior to January 1 of the reporting year, not paid as of June 30 of the reporting year; \$ _____
 - 6. Pro-rata share of the reimbursable net paid loss assessment paid by the carrier during the preceding calendar year pursuant to N.J.A.C. 11:20-2.17; [i x (ii ÷ iii)] = \$ _____
 - i. Total net paid loss assessment \$ _____
 - ii. Net earned premium for standard health benefits plans \$ _____
 - iii. Net earned premium for all health benefits plans \$ _____
- C. Loss Ratio (B ÷ A) = _____ (If less than 75%, fill out D and E below)

D. Amount entered on line B \div .75 = \$ _____
 E. Amount to be refunded to policy or contract holders (A - D) = \$ _____

If the amount entered on line C is less than 75%, you must attach to this Report a refund plan that conforms with N.J.A.C. 11:20-7.5. Please submit this form and a refund plan to the address listed in N.J.A.C. 11:20-2.1(h).

I certify that the above information is accurate, complete and has been prepared in accordance with N.J.S.A. 27A-9e(1) and (2) and N.J.A.C. 11:20-7.

 Actuary's Signature

 Actuary's Name (Please print clearly)

 Title Date

 Telephone Number

 Facsimile Number

Amended by R.1996 d.193, effective April 15, 1996.
 See: 27 N.J.R. 4493(a), 28 N.J.R. 2008(a).

Amended by R.1998 d.443, effective August 7, 1998.
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

EXHIBIT K

New Jersey Individual Health Coverage Program
Carrier Market Share and Net Paid Gain (Loss) Report

This Report must be completed in accordance with the provisions of N.J.A.C. 11:20-8, and certified to by the Chief Financial Officer or other duly authorized officer of the Carrier. Reports must be completed and returned on or before March 1, 1999 and March 1 of the year immediately following every Two-Year Calculation Period, as defined in N.J.A.C. 11:20-1.2, thereafter. Completed Reports must be returned to the Executive Director at the address listed in N.J.A.C. 11:20-2.1(h).

Part A. Carrier Information

- 1. Carrier's Name:
2. Carrier's NAIC Number (including Group):
3. Is the specifically-named carrier an Affiliated Carrier?
a. If Yes, is this Report the combined Report for all Affiliated Carriers, or for the specifically named Carrier?
b. If for all Affiliated Carriers, list the affiliated carriers and ATTACH specifically named Carrier Reports to the combined Report.
4. Is this a revised report intended to replace a previously submitted Exhibit K?

Part B. Personal Respondent Information

- 1. Name:(print or type)
2. Title:
3. Telephone No.: Facsimile No.
4. Mailing Address:

Part C. Information for Two-Year Calculation Period for calendar years:

- 1. Net Earned Premium:
a. for all individual and group health benefits plans
2. Number of non-group persons enrolled by the Carrier:
a. Community rated persons
b. Community rated conversion policy persons
c. Medicaid recipients
d. Medicare cost and risk lives
e. Two-Year non-group total

f. Average non-group enrollment (line e divided by 8): _____

3. Net paid gain / (loss) report for community rated Individual Health Benefits Plans:

- a. PREMIUM EARNED \$ _____
- b. CLAIMS PAID \$ _____
- c. NET INVESTMENT INCOME \$ _____
- d. NET PAID GAIN / (LOSS) \$ _____
 115% (C3a + C3c) - C3b

_____ Exempt carrier, not eligible for reimbursement
 _____ Non-exempt carrier, seeking reimbursement of net paid loss shown in C3d above

Part D. Certification

I certify that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.A.C. 11:20-8.

 Signature Title Date

Amended by R.1998 d.443, effective August 7, 1998.
 See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).

EXHIBIT R

[Carrier]
MANDATED OFFER RIDER
[Policyholder]
[Policy No.]
Effective Date:

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in Plans B-E:

Item j. of the Transplant Benefits section of the COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is replaced with the following:

- j. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- k. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plans B-E and HMO should use the following text in the HMO Plan:

Item 23. of the INPATIENT, HOSPITAL, REHABILITATION CENTER & SKILLED NURSING CENTER BENEFITS provision of the COVERED SERVICES AND SUPPLIES section of the Contract is replaced with the following:

- 23. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- 24. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.]

[Carriers that elect to make the optional benefit required by P.L. 1995, c.100 available by rider in Plan A should use the following text: THE COVERED CHARGES WITH SPECIAL LIMITATIONS provision of the HEALTH BENEFITS INSURANCE section of the Policy is expanded to include the following:

Transplants: We cover Medically Necessary and Appropriate Services and Supplies for:

- a. Autologous Bone Marrow Transplant and Associated Dose-Intensive Chemotherapy, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
- b. Peripheral Blood Stem Cell Transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

Transplant services must be authorized by Us. Please see the section called "Utilization Review" for details on how to confirm that Your transplant will be a Covered Charge.]

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].

[Carrier should insert standard amendment closure and signature blocks.]

New Rule, R.1995 d.579, effective November 6, 1995 (operative January 1, 1996).
See: 27 N.J.R. 3008(a), 27 N.J.R. 4328(a).

Amended by R.1997 d.279, effective July 7, 1997 (operative September 1, 1997).
See: 29 N.J.R. 1011(a), 29 N.J.R. 2854(a).

EXHIBIT S

[Carrier]
AMENDMENT
[Policyholder]
Effective Date:
[
]

This Amendment is part of the [Policy]. Except as stated above, nothing in this Amendment changes or affects any other terms of the [Policy].
[Carrier shall insert its standard amendment closure and signature blocks.]

New Rule, R.1996 d.542, effective December 2, 1996.
See: 28 N.J.R. 3704(a), 28 N.J.R. 5075(a).

EXHIBIT T

EXPLANATION OF BRACKETS FOR INDIVIDUAL HEALTH COVERAGE STANDARD PLANS AND APPLICATION
{January 1998}

Text which is enclosed in brackets may *only* be modified as described in this Exhibit. Unless otherwise stated, carriers have the option to either include or not include the standard text.

Plans B - E

- 1) The name of the Carrier, specific dates, page numbers, deductible amounts or premium information may be inserted, as appropriate.
- 2) **Dividend** text on the face page and in the General Provisions should only be included by mutual carriers.
- 3) The definition of **Care Manager** should only be included by carriers that utilize such a provider.
- 4) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee only if the plan is issued through or in conjunction with a Selective Contracting Arrangement.
- 5) Omit the **definitions** of Network Provider, Out-Network Provider and Service Area for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
- 6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
- 7) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
- 8) Omit the **PPO, POS and Appeals** sections for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
- 9) The **Coinsurance Cap** provision in the Benefit Deductibles, Copayments and Coinsurance section should be included in plans which are *not* issued through or in conjunction with a selective Contracting Arrangement. Omit the Coinsured Charge Limit provision. Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Hospital Charges** section.
- 10) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available *via rider* should include the text of the first item "j" in the Transplant section. Omit the second item "j" and item "k". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "j" in the Transplant section. Include the second item "j" and item "k".
- 12) Carriers that do not use centers of excellence should omit the **Centers of Excellence** section.
- 13) Carriers may elect to omit the **Provider Relationship** provision in the General provisions.
- 14) Omit the **Network and Out-Network Provider Relationship** provision in the General Provisions for plans which are *not* issued through or in conjunction with a Selective Contracting Arrangement.
- 15) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Policy-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.
- 16) Carriers that issue Point of Service plans may elect to allow a female Covered Person to use the services of a **network gynecologist** without PCP referral for stated services on an unlimited basis, or may limit the use of a network gynecologist without PCP referral to once per year. Include only the paragraph in the Point of Service provisions which reflects the elected option.

Plans issued through or in conjunction with a Selective Contracting Arrangement:

- 1) Include the following definitions:
 - Network provider
 - Out-Network Provider
 - Service Area
- 2) The definition of **Reasonable and Customary Charges** should include the reference to the negotiated fee.
- 3) Sample **Schedule** text is included for a PPO plan without copayments, a PPO plan with copayments, and a POS plan. For plans which use copayments, include only the categories of services to which a copay will apply. The dollar amounts of the copayments should be consistent with the copayment options available with the IHC HMO plan.
- 4) Include the Preferred Provider Organization section if the plan is a PPO. Include the name of the PPO wherever XYZ appears.
- 5) Include the Point of Service section if the plan is a POS. Include the name of the provider organization wherever XYZ appears.
- 6) Carriers issuing a PPO or a POS plan may include **Appeals Procedures**.
- 7) Include the **Coinsured Charge Limit** text in the Benefit Deductibles, Copayments and Coinsurance section. The Coinsurance Cap provision should be omitted.
- 8) Include the Network and Out-Network Provider relationship provision in the General Provisions.

Plans issued with \$1500 and \$2250 High Deductible Options (that could be used in conjunction with an MSA):

- 1) Include only the **Schedule of Benefits** page which specifies the high deductible options. Omit all other schedules.
- 2) Include the **Benefit Deductibles, Copayments and Coinsurance** section which addresses the maximum out of pocket amount. Omit the corresponding section which addresses Coinsurance Cap/Coinsured Charge Limit.

HMO Plan

- 1) The name of the Carrier, specific dates, page numbers, copayment amounts or premium information may be inserted, as appropriate.
- 2) Wherever a series of terms are shown in brackets, select the term that is consistent with the carrier's terminology or practice.

- 3) Omit **Care Manager** definition if a care manager is not used.
- 4) Omit **Coinsurance** definition if prescription drugs are provided subject to a copayment.
- 5) Omit **Health Center** definition if not applicable.
- 6) **Child(ren) Coverage** should only be included in the Types of Coverage section and included in the Premium text by carriers that elect to make this child only option available.
- 7) Carriers that require that the person live, reside or work in the Service Area as an eligibility criteria should include the bracketed text; and also include the bracketed termination text which addresses when a person no longer lives, resides or works in the Service Area.
- 8) Bracketed text is shown in the **Payment of Premiums-Grace Period** and **Termination of the Contract-Renewal Privilege** sections to accommodate termination as of the end of the grace period or as of the paid-to-date. Include appropriate bracketed text.
- 9) The last two sentences of the **Payment of Premiums-Grace Period** provision should be omitted by carriers that do not charge interest in connection with the payment of a late premium.
- 10) Carriers that do not have a home care program should omit the text from the 48 hour maternity portion of the **Inpatient Hospital** section.
- 11) Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants available via *rider* should include the text of the first item "23" in the Transplant section. Omit the second item "23" and item "24". Carriers that elect to make the optional **Transplant** coverage for autologous bone marrow transplant and peripheral blood stem cell transplants as *part of the standard plan* should omit the text of the first item "23" in the Transplant section. Include the second item "23" and item "24".
- 12) The **Dispensing limits for prescription drugs** should be included in the Exclusions section by carriers that impose such limits.
- 13) In the event of termination due to fraud, carriers may elect to either terminate coverage back to the effective date, or may terminate coverage immediately. Item "b" of the **Termination of the Contract-Renewal Privilege** should reflect the option the carrier has chosen. Carriers must make one election, for all plans, to terminate coverage as of the effective date or immediately; the election may not be made on a case by case basis.

Application

- 1) Omit those bracketed Instructions and bracketed text which do not apply.
- 2) Use the term Policy or Contract, as appropriate.
- 3) Use the term insured, subscriber or member, as appropriate.
- 4) If proof of full time student status or disability is not required to be attached to the application, the text which directs that proof be attached should be deleted.
- 5) In the Coverage section, carriers should include text which is consistent with the standard plan options that the carrier offers.
- 6) Omit the quarterly and/or semi-annual premium payment modes if those modes are not available.
- 7) The use of the Pre-Existing Conditions Statement is optional.
- 8) The statement regarding the selection of a PCP may be included, at the option of the carrier.
- 9) The statement regarding the option to elect coverage for ABMT should only be included by those carriers that make the benefit available via rider.
- 10) The variable text a carrier includes in the statement regarding termination in the event of falsified information should be consistent with the election of the carrier regarding termination as of the effective date, or immediately. Refer to item 15 of the explanation for Plans B - E, and item 13 of the explanation for the HMO plan.
- 11) Agent/Producer information may be consistent with a Carrier's usual procedures for securing data regarding the agent/producer for the purpose of commission payments.

New Rule, R.1997 d.477, effective January 1, 1998.
See: 29 N.J.R. 4381(a), 29 N.J.R. 5023(b).

Amended by R.1998 d.443, effective August 7, 1998.
See: 30 N.J.R. 2581(a), 30 N.J.R. 3289(a).