

CHAPTER 4

ACTUARIAL SERVICES

Authority

N.J.S.A. 17:1C-6e.

Source and Effective Date

R.1996 d.4, effective November 30, 1995.
See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Executive Order No. 66(1978) Expiration Date

Chapter 4, Actuarial Services, expires on November 30, 2000.

Chapter Historical Note

Chapter 4, Actuarial Services, was filed and became effective prior to September 1, 1969.

1972 Revisions: Subchapter 2, Replacement of Life Insurance Policy, was originally filed and became effective April 1, 1972 as R.1972 d.21.

1973 Revisions: Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was filed March 23, 1973 as R.1973 d.82, effective April 15, 1973, for automobile insurance; and effective July 1, 1973, for all other lines of insurance. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

1974 Revisions: Subchapter 8, Charitable Annuities, was adopted as new rules by R.1974 d.258, effective September 20, 1974. See: 6 N.J.R. 315(a), 6 N.J.R. 399(c).

1976 Revisions: Subchapter 11, Life Insurance Solicitation, was adopted as new rules by R.1976 d.329, effective October 18, 1976. See: 8 N.J.R. 336(a), 8 N.J.R. 517(a).

1977 Revisions: Subchapter 13, Group Student Health Insurance, was adopted as new rules by R.1977 d.309, effective August 22, 1977. See: 9 N.J.R. 343(c), 9 N.J.R. 438(d). Subchapter 14, Home Health Care Insurance Coverage, was adopted as new rules by R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

1978 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1978 d.165, effective May 22, 1978. See: 10 N.J.R. 162(a), 10 N.J.R. 257(a).

1979 Revisions: Subchapter 20, Blindness; Partial Blindness or other Physical or Mental Impairments; Unfair Discrimination, was adopted as new rules by R.1979 d.434, effective December 6, 1979. See: 11 N.J.R. 384(a), 11 N.J.R. 627(f).

1980 Revisions: Subchapter 16, Minimum Standards for Individual Health Insurance; Subchapter 17, Health Insurance Solicitation; and Subchapter 18, Individual Health Insurance Rate Filings, were adopted as new rules by R.1980 d.176, effective April 21, 1980. See: 11 N.J.R. 348(a), 12 N.J.R. 342(c). On June 12, 1980, the New Jersey Legislature adopted Senate Concurrent Resolution 110 disapproving Subchapters 16, 17 and 18 pursuant to N.J.S.A. 17B:26-45d. On August 5, 1980, the Department of Insurance readopted Subchapters 16, 17 and 18 in their entirety, with amendments to N.J.A.C. 11:4-16.8(b), 11:4-17.6 and 11:4-17.7, as R.1980 d.343. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b). Subchapter 21, Limited Death Benefits Forms, was adopted as new rules by R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

1982 Revisions: The existing text of Subchapter 2, Replacement of Life Insurance Policy, was repealed and new rules were adopted as R.1982 d.16, effective February 1, 1982 (operative June 1, 1982). See: 13 N.J.R. 18(e), 14 N.J.R. 158(d).

1983 Revisions: Pursuant to Executive Order No. 66(1978), Subchapter 15, Alcoholism Benefits, expired on May 22, 1983.

1984 Revisions: Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as new rules by R.1984 d.478, effective November 5, 1984. See: 16 N.J.R. 1452(a), 16 N.J.R. 3040(a). Pursuant to Executive Order No. 66(1978), Subchapter 6, Reserve Standards for Individual Health Insurance Policies, was readopted as R.1984 d.512, effective November 5, 1984. See: 16 N.J.R. 2225(a), 16 N.J.R. 3039(a).

1985 Revisions: Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as new rules by R.1985 d.70, effective February 19, 1985 (operative June 19, 1985). See: 16 N.J.R. 2945(a), 17 N.J.R. 460(a). Pursuant to Executive Order No. 66(1978), Subchapter 20 was readopted as R.1985 d.161, effective April 1, 1985. See: 17 N.J.R. 168(a), 17 N.J.R. 820(a). Pursuant to Executive Order No. 66(1978), Subchapters 16, 17 and 18 were readopted as R.1985 d.221, effective April 15, 1985. See: 17 N.J.R. 554(a), 17 N.J.R. 1129(a). Subchapter 21 was readopted as R.1985 d.325, effective June 3, 1985. See: 17 N.J.R. 891(a), 17 N.J.R. 1660(a). Subchapter 24, Smoker and Non-smoker Mortality Tables, was adopted as new rules by R.1985 d.617, effective December 2, 1985. See: 17 N.J.R. 2348(a), 17 N.J.R. 2907(a). Subchapter 26, Annuity Mortality Tables, was adopted as new rules by R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

1986 Revisions: Subchapter 15, Alcoholism Benefits, was adopted as new rules by R.1986 d.228, effective June 16, 1986. See: 18 N.J.R. 607(a), 18 N.J.R. 1302(a).

1988 Revisions: Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as new rules by R.1988 d.455, effective September 19, 1988. See: 20 N.J.R. 43(a), 20 N.J.R. 2377(c). Subchapter 28, Group Coordination of Benefits, was adopted as new rules by R.1988 d.499, effective October 17, 1988. See: 20 N.J.R. 1773(b), 20 N.J.R. 2581(a).

1989 Revisions: Subchapter 29, Homeowners Comparison Survey, was adopted as new rules by R.1989 d.50, effective January 17, 1989. See: 20 N.J.R. 2181(a), 21 N.J.R. 164(a). Subchapter 31, Term Life Insurance Comparison Survey, was adopted as new rules by R.1989 d.122, effective February 21, 1989. See: 20 N.J.R. 2990(a), 21 N.J.R. 566(a). Subchapter 32, Health Service Corporation Notice of Increased Rates, was adopted as R.1989 d.522, effective October 2, 1989. See: 21 N.J.R. 973(b), 21 N.J.R. 3173(c). Subchapter 33, Excess Interest Reserve Adjustment, was adopted as new rules by R.1989 d.523, effective October 2, 1989. See: 21 N.J.R. 1308(a), 21 N.J.R. 3175(c). Subchapter 34, Long-Term Care Insurance, was adopted as new rules by R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

1990 Revisions: Subchapter 25 regarding Medicare supplement interim standards, was adopted as new rules by R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

1991 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990. As part of R.1991 d.3, Subchapter 1, Contracts on a Variable Basis, was repealed effective January 7, 1991. See: 22 N.J.R. 1689(a), 23 N.J.R. 111(a). Subchapter 35, Annual Medicare Supplement Policy Survey, was adopted as new rules by R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a). Subchapter 23, Medicare Supplement Policies and Contracts, was changed to Minimum Standards for Medicare Supplement Coverage by R.1991 d.345, effective July 1, 1991. See: 23 N.J.R. 1264(a), 23 N.J.R. 2014(a). Notice of Action on Petition for Rulemaking: Regulation of Authority on Group Health Insurance Contracts. See: 23 N.J.R. 2546(c). Denial of Petition for Rulemaking: Declaration of Authority to Regulate Group Health Insurance Contracts. See: 23 N.J.R. 3827(a).

1993 Revisions: Subchapter 25 was repealed by R.1993 d.26, effective January 4, 1993. See: 24 N.J.R. 12(a), 25 N.J.R. 141(a).

1994 Revisions: Subchapter 37, Selective Contracting Arrangements of Insurers, was adopted as new rules by R.1994 d.45, effective January 18, 1994. See: 25 N.J.R. 4554(b), 26 N.J.R. 381(a).

1995 Revisions: Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as new rules by R.1995 d.406, effective August 7, 1995. See: 27 N.J.R. 1356(b), 27 N.J.R. 2931(a). Subchapter 30, Accelerated Death Benefits, was adopted as new rules by R.1995 d.521, effective September 18, 1995. See: 27 N.J.R. 2046(a), 27 N.J.R. 3613(c). Subchapter 40, Life/Health/Annuity Forms, was adopted as new rules by R.1995 d.569, effective November 6, 1995. See: 27 N.J.R. 2857(a), 27 N.J.R. 2867(a), 27 N.J.R. 4317(a). An administrative correction, published November 20, 1995, restored comments to the notice of adoption of Subchapter 40 which were inadvertently omitted. See: 27 N.J.R. 4728(a).

1996 Revisions: Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1996 d.4, effective November 30, 1995. As part of R.1996 d.4, Subchapter 5, Amendment to Instructions to Life and Accident and Health Annual Statement Blank; Subchapter 10, Expense Experience; Subchapter 32, Health Service Corporation Notice of Increased Rates; Subchapter 35, Annual Medicare Supplement Policy Survey; and Exhibits A and B of the Appendix to Subchapters 16 and 23 were repealed effective January 2, 1996. See: Source and Effective Date. See, also, section annotations.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 1. (RESERVED)

SUBCHAPTER 2. REPLACEMENT OF LIFE INSURANCE POLICY

- 11:4-2.1 Purpose
- 11:4-2.2 Definitions
- 11:4-2.3 Exemptions
- 11:4-2.4 Duties of agent
- 11:4-2.5 Duties of replacing insurers
- 11:4-2.6 Duties of insurers with respect to direct-response sales
- 11:4-2.7 Duties of the existing insurer
- 11:4-2.8 Penalties
- 11:4-2.9 Separability

SUBCHAPTER 3. COUPON POLICIES AND POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-3.1 Payments
- 11:4-3.2 Gross premium shown
- 11:4-3.3 Gross premium regarding additional insurance
- 11:4-3.4 Coupons
- 11:4-3.5 Guaranteed annual endowments
- 11:4-3.6 Severability
- 11:4-3.7 Effective date

SUBCHAPTER 4. PASSBOOKS USED IN CONNECTION WITH COUPON POLICIES OR POLICIES CONTAINING GUARANTEED ANNUAL ENDOWMENT BENEFITS

- 11:4-4.1 General provisions
- 11:4-4.2 Unfair practice
- 11:4-4.3 Scope
- 11:4-4.4 Severability
- 11:4-4.5 Effective date

SUBCHAPTER 5. (RESERVED)

SUBCHAPTER 6. RESERVE STANDARDS FOR INDIVIDUAL HEALTH INSURANCE POLICIES

- 11:4-6.1 Purpose
- 11:4-6.2 Scope
- 11:4-6.3 Definitions
- 11:4-6.4 Active life reserve—general
- 11:4-6.5 Types of individual health insurance policies

- 11:4-6.6 Reserve standards for policies of Type A, B or C
- 11:4-6.7 Reserve standards for policy Type D
- 11:4-6.8 Claim reserves; present value of amounts not yet due on claims
- 11:4-6.9 Loss of time policies
- 11:4-6.10 Tabular reserves; deficiency reserve requirement
- 11:4-6.11 Commissioner's Disability Table
- 11:4-6.12 Active life reserve factors; elimination period
- 11:4-6.13 Policy applicability
- 11:4-6.14 Severability

SUBCHAPTER 7. PROCEDURE FOR THE REGULATION OF CONSENT TO HIGHER RATE FILINGS

- 11:4-7.1 Filing requirements
- 11:4-7.2 Premium charges
- 11:4-7.3 Approval of applications

SUBCHAPTER 8. CHARITABLE ANNUITIES

- 11:4-8.1 Purpose
- 11:4-8.2 Forms of agreement
- 11:4-8.3 Annuity rates
- 11:4-8.4 Surplus and reserves
- 11:4-8.5 Compliance with investment requirements
- 11:4-8.6 Annual report
- 11:4-8.7 Special permit
- 11:4-8.8 Separability of provisions
- 11:4-8.9 Penalties

SUBCHAPTER 9. PERSONAL LINES INSURANCE: PROSPECTIVE LOSS COSTS FILING PROCEDURES

- 11:4-9.1 Purpose and scope
- 11:4-9.2 Definitions
- 11:4-9.3 Prospective loss cost filing requirements for rating organizations
- 11:4-9.4 Prospective loss costs filing requirements for insurers
- 11:4-9.5 Penalties

APPENDIX A

APPENDIX B

SUBCHAPTER 10. (RESERVED)

SUBCHAPTER 11. LIFE INSURANCE SOLICITATION

- 11:4-11.1 Authority
- 11:4-11.2 Purpose
- 11:4-11.3 Scope
- 11:4-11.4 Definitions
- 11:4-11.5 Disclosure requirements
- 11:4-11.6 General provisions
- 11:4-11.7 Failure to comply
- 11:4-11.8 Effective date

APPENDIX

SUBCHAPTER 12. STUDENT LIFE INSURANCE

- 11:4-12.1 Student life insurance solicitation

SUBCHAPTER 13. GROUP STUDENT HEALTH INSURANCE

- 11:4-13.1 Scope
- 11:4-13.2 Definitions
- 11:4-13.3 Prohibited provisions

SUBCHAPTER 14. HOME HEALTH CARE INSURANCE COVERAGE

- 11:4-14.1 Scope
- 11:4-14.2 Definitions
- 11:4-14.3 Home health care benefits required

ACTUARIAL SERVICES

- 11:4-14.4 Exclusions
- 11:4-14.5 Effective date

SUBCHAPTER 15. ALCOHOLISM BENEFITS

- 11:4-15.1 Scope
- 11:4-15.2 Benefits
- 11:4-15.3 Exclusions

SUBCHAPTER 16. MINIMUM STANDARDS FOR INDIVIDUAL HEALTH INSURANCE

- 11:4-16.1 Purpose
- 11:4-16.2 Applicability and scope
- 11:4-16.3 Effective date
- 11:4-16.4 Policy definitions
- 11:4-16.5 Prohibited policy provisions
- 11:4-16.6 Minimum standards for benefits
- 11:4-16.7 Application forms
- 11:4-16.8 Required disclosure provisions
- 11:4-16.9 Forms submission requirements
- 11:4-16.10 Separability
- 11:4-16.11 Penalties

APPENDIX A

SUBCHAPTER 17. HEALTH INSURANCE SOLICITATION

- 11:4-17.1 Purpose
- 11:4-17.2 Applicability and scope
- 11:4-17.3 Definitions
- 11:4-17.4 Unfair and deceptive acts
- 11:4-17.5 Replacement
- 11:4-17.6 Complaint record to be maintained
- 11:4-17.7 Penalties
- 11:4-17.8 Separability
- 11:4-17.9 Effective date

SUBCHAPTER 18. INDIVIDUAL HEALTH INSURANCE RATE FILINGS

- 11:4-18.1 Purpose
- 11:4-18.2 Applicability and scope
- 11:4-18.3 Definitions
- 11:4-18.4 Rate submission requirements
- 11:4-18.5 Loss ratio standards
- 11:4-18.6 Annual review of calendar year experience data on filed individual health insurance policy forms
- 11:4-18.7 Rate manual
- 11:4-18.8 Separability
- 11:4-18.9 Penalties
- 11:4-18.10 Compliance

SUBCHAPTER 19. OPTIONAL COVERAGE FOR PREGNANCY AND CHILDBIRTH BENEFITS

- 11:4-19.1 Purpose
- 11:4-19.2 Scope
- 11:4-19.3 Second surgical opinions
- 11:4-19.4 Maternity benefits option

SUBCHAPTER 20. BLINDNESS; PARTIAL BLINDNESS OR OTHER PHYSICAL OR MENTAL IMPAIRMENT; UNFAIR DISCRIMINATION

- 11:4-20.1 Purpose
- 11:4-20.2 Unfair discriminatory acts or practices

SUBCHAPTER 21. LIMITED DEATH BENEFITS FORMS

- 11:4-21.1 Purpose; scope
- 11:4-21.2 Definitions
- 11:4-21.3 General requirements
- 11:4-21.4 Severability

SUBCHAPTER 22. INDIVIDUAL LIFE INSURANCE: USE OF GENDER BLENDED MORTALITY TABLES

- 11:4-22.1 Purpose
- 11:4-22.2 Definitions
- 11:4-22.3 Construction of gender blended tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.4 Construction of Gender Blended Smoker and Nonsmoker Mortality Tables for use in the determination of minimum nonforfeiture benefits and minimum reserves
- 11:4-22.5 Use of gender blended mortality tables in the non-Norris market
- 11:4-22.6 Effect on previously filed forms
- 11:4-22.7 Unfair discrimination
- 11:4-22.8 Separability

APPENDIX A

APPENDIX B

SUBCHAPTER 23. MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT COVERAGE

- 11:4-23.1 Purpose
- 11:4-23.2 Applicability and scope
- 11:4-23.3 Definitions
- 11:4-23.4 Policy definitions and terms
- 11:4-23.5 Policy provisions
- 11:4-23.6 General minimum benefit standards
- 11:4-23.7 Minimum benefits for policies and certificates delivered or issued for delivery prior to January 4, 1993
- 11:4-23.8 Minimum benefit standards for policies and certificates delivered or issued for delivery on or after January 4, 1993
- 11:4-23.9 Open enrollment
- 11:4-23.10 Standards for claims payment
- 11:4-23.11 Loss ratio standards, annual filing of premium rates and refund or credit calculation
- 11:4-23.12 Filing requirements for policies, certificates and premium rates
- 11:4-23.13 Compensation arrangements
- 11:4-23.14 Required disclosure provisions
- 11:4-23.15 Requirements for application forms and replacement coverage
- 11:4-23.16 Filing requirements for advertising
- 11:4-23.17 Standards for marketing
- 11:4-23.18 Appropriateness of recommended purchase and excessive coverage
- 11:4-23.19 Reporting of multiple policies
- 11:4-23.20 Addresses for submission for filing
- 11:4-23.21 Penalties
- 11:4-23.22 Severability

APPENDIX TO SUBCHAPTERS 16 AND 23

EXHIBITS A AND B (RESERVED)

- EXHIBIT C
- EXHIBIT D
- EXHIBIT E
- EXHIBIT F
- EXHIBIT G
- EXHIBIT H

SUBCHAPTER 23A. MEDICARE SUPPLEMENT—UNDER 50 COVERAGE

- 11:4-23A.1 Purpose and scope
- 11:4-23A.2 Definitions
- 11:4-23A.3 Creation of Medicare Supplement—Under 50 Coverage Plan
- 11:4-23A.4 Governing Board
- 11:4-23A.5 Plan of operation
- 11:4-23A.6 Open enrollment
- 11:4-23A.7 Rates

- 11:4-23A.8 Reports
- 11:4-23A.9 Equitable sharing of losses and audit
- 11:4-23A.10 Assessments
- 11:4-23A.11 Appeal to the Commissioner
- 11:4-23A.12 Assessment relief requests

SUBCHAPTER 23B. MEDICARE SUPPLEMENT—AGE 50 THROUGH 64 COVERAGE

- 11:4-23B.1 Purpose and scope
- 11:4-23B.2 Definitions
- 11:4-23B.3 Open enrollment
- 11:4-23B.4 Rates

SUBCHAPTER 24. SMOKER AND NONSMOKER MORTALITY TABLES

- 11:4-24.1 Purpose
- 11:4-24.2 Definitions
- 11:4-24.3 Smoker and nonsmoker mortality tables
- 11:4-24.4 Juvenile insureds
- 11:4-24.5 Separability

SUBCHAPTER 25. FUNERAL INSURANCE POLICIES

- 11:4-25.1 Purpose; scope
- 11:4-25.2 Definitions
- 11:4-25.3 Forms submission requirements
- 11:4-25.4 Disclosure requirements
- 11:4-25.5 Loss ratio standard
- 11:4-25.6 Severability
- 11:4-25.7 Penalties

SUBCHAPTER 26. ANNUITY MORTALITY TABLES

- 11:4-26.1 Purpose
- 11:4-26.2 Definitions
- 11:4-26.3 Individual annuity or pure endowment contracts
- 11:4-26.4 Group annuity or pure endowment contracts
- 11:4-26.5 Separability

SUBCHAPTER 27. REPORTING A LIQUOR LAW LIABILITY LOSS EXPERIENCE STATISTICS

- 11:4-27.1 Purpose
- 11:4-27.2 Scope
- 11:4-27.3 Definitions
- 11:4-27.4 Schedule and procedures for reporting liquor law liability loss experience statistics
- 11:4-27.5 Penalties

APPENDIX A

APPENDIX B

SUBCHAPTER 28. GROUP COORDINATION OF BENEFITS

- 11:4-28.1 Purpose; applicability
- 11:4-28.2 Definitions
- 11:4-28.3 Coordination permissive
- 11:4-28.4 Model COB contract provision
- 11:4-28.5 Prohibited coordination; benefit design
- 11:4-28.6 Rules for coordination of benefits
- 11:4-28.7 Procedure to be followed by secondary plan to reduce benefits
- 11:4-28.8 Reasonable monetary value of services
- 11:4-28.9 Excess and other nonconforming provisions
- 11:4-28.10 Substitute terminology in contracts
- 11:4-28.11 Compliance
- 11:4-28.12 Severability

APPENDIX A

SUBCHAPTER 29. HOMEOWNERS COMPARISON SURVEY

- 11:4-29.1 Purpose and scope
- 11:4-29.2 Definitions
- 11:4-29.3 Coverage option survey requirements

APPENDIX A

APPENDIX B

APPENDIX C

SUBCHAPTER 30. ACCELERATED DEATH BENEFITS

- 11:4-30.1 Purpose
- 11:4-30.2 Application and scope
- 11:4-30.3 Definitions
- 11:4-30.4 Permitted forms of accelerated death benefit provisions
- 11:4-30.5 Partial surrender
- 11:4-30.6 Lien
- 11:4-30.7 Payment options
- 11:4-30.8 Terms of accelerated death benefit contract provisions
- 11:4-30.9 Exercise of the option to accelerate the payment of death benefits
- 11:4-30.10 Form submission requirements
- 11:4-30.11 Illustrations
- 11:4-30.12 Discrimination
- 11:4-30.13 Severability
- 11:4-30.14 Effect on previously filed forms

SUBCHAPTER 31. TERM LIFE INSURANCE COMPARISON SURVEY

- 11:4-31.1 Purpose and scope
- 11:4-31.2 Definitions
- 11:4-31.3 Coverage option survey
- 11:4-31.4 Survey forms

APPENDIX A

APPENDIX B

APPENDIX C

SUBCHAPTER 32. (RESERVED)

SUBCHAPTER 33. EXCESS INTEREST RESERVE ADJUSTMENT

- 11:4-33.1 Purpose
- 11:4-33.2 Applicability and scope
- 11:4-33.3 Requirements
- 11:4-33.4 Separability

SUBCHAPTER 34. LONG-TERM CARE INSURANCE

- 11:4-34.1 Purpose
- 11:4-34.2 Applicability and scope
- 11:4-34.3 Definitions
- 11:4-34.4 Filing requirement
- 11:4-34.5 Policy definitions
- 11:4-34.6 Policy practices, provisions and prohibitions
- 11:4-34.7 Continuation or conversion of group coverage
- 11:4-34.8 Required disclosure provisions
- 11:4-34.9 Requirements for replacement
- 11:4-34.10 Discretionary powers of the Commissioner
- 11:4-34.11 Outline of coverage
- 11:4-34.12 Severability
- 11:4-34.13 Actuarial requirements for rate submissions
- 11:4-34.14 Loss ratio standards for individual long-term care insurance
- 11:4-34.15 Spousal discount

ACTUARIAL SERVICES

SUBCHAPTERS 35 THROUGH 36. (RESERVED)

SUBCHAPTER 37. SELECTIVE CONTRACTING ARRANGEMENTS OF INSURERS

- 11:4-37.1 Purpose and scope
- 11:4-37.2 Definitions
- 11:4-37.3 Standards for selective contracting arrangements
- 11:4-37.4 Selective contracting arrangement approval and amendment procedures
- 11:4-37.5 Confidentiality
- 11:4-37.6 Denial, suspension and revocation
- 11:4-37.7 Monitoring; auditing
- 11:4-37.8 Filing and review fees
- 11:4-37.9 Penalties

SUBCHAPTERS 38 THROUGH 39. (RESERVED)

SUBCHAPTER 40. LIFE/HEALTH/ANNUITY FORMS

- 11:4-40.1 Purpose and scope
- 11:4-40.2 Definitions
- 11:4-40.3 Life/health/annuity form approval standards
- 11:4-40.4 General requirements
- 11:4-40.5 Life/health/annuity form approval procedures
- 11:4-40.6 Individual life and annuities variable form approval procedures
- 11:4-40.7 Valuation and non-forfeiture interest rates form approval procedures
- 11:4-40.8 Certificate of assumption form approval procedures
- 11:4-40.9 File and use eligibility
- 11:4-40.10 File and use procedures
- 11:4-40.11 Service fees

APPENDIX

SUBCHAPTER 41. STANDARDS FOR INDIVIDUAL LIFE INSURANCE POLICY FORMS

- 11:4-41.1 Purpose and scope
- 11:4-41.2 Definitions
- 11:4-41.3 General standards
- 11:4-41.4 Exclusions and prohibitions
- 11:4-41.5 Prohibition of bail-out features
- 11:4-41.6 Indexed benefits
- 11:4-41.7 Standards for pre-existing conditions exclusions
- 11:4-41.8 Standards for field issue contracts
- 11:4-41.9 Standards for extension or cancellation of maturity dates
- 11:4-41.10 Standards for policy split options
- 11:4-41.11 Standards for other insured coverage
- 11:4-41.12 Standards for designated life options
- 11:4-41.13 Standards for survivorship forms
- 11:4-41.14 Standards for re-entry or requalification features
- 11:4-41.15 Standards for custom design products
- 11:4-41.16 Effect on previously filed forms

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

- 11:4-42.1 Purpose and scope
- 11:4-42.2 Definitions
- 11:4-42.3 Applicability of other standards
- 11:4-42.4 General standards
- 11:4-42.5 Prohibited provisions
- 11:4-42.6 Provisions for aggregate limits
- 11:4-42.7 Provisions for offsets in group policies and certificates providing disability income insurance
- 11:4-42.8 Provisions setting forth pre-authorization requirements
- 11:4-42.9 Provisions for pre-existing condition exclusions and limitations
- 11:4-42.10 Provisions for subrogation and repayment of benefits
- 11:4-42.11 Provisions concerning exclusions and limitations for the use of alcohol and drugs or relating to illegal occupations
- 11:4-42.12 Provisions for payment of benefits payable for automobile related injuries

- 11:4-42.13 Conversion of group life insurance coverage to an individual life insurance policy

APPENDIX

SUBCHAPTER 43. INDIVIDUAL ANNUITY CONTRACT FORM STANDARDS

- 11:4-43.1 Purpose and scope
- 11:4-43.2 Definitions
- 11:4-43.3 General requirements and prohibitions
- 11:4-43.4 Individual immediate annuities
- 11:4-43.5 Individual deferred annuities
- 11:4-43.6 Waiver of surrender charges
- 11:4-43.7 Surrender charges for individual deferred annuities

SUBCHAPTER 44. STANDARDS FOR CONTRACTS ON A VARIABLE BASIS

- 11:4-44.1 Purpose and scope
- 11:4-44.2 Definitions
- 11:4-44.3 Standards for variable contracts
- 11:4-44.4 Prohibited provisions
- 11:4-44.5 Standards for individual market value adjusted annuities

SUBCHAPTER 45. PERIODIC REPORTS

- 11:4-45.1 Purpose and scope
- 11:4-45.2 Definitions
- 11:4-45.3 General requirements
- 11:4-45.4 Flexible factor forms; reporting requirements
- 11:4-45.5 Individual variable annuity forms; reporting requirements
- 11:4-45.6 Individual variable life insurance; periodic report requirements
- 11:4-45.7 Penalties

SUBCHAPTER 46. SYNTHETIC GUARANTEED INVESTMENT CONTRACT FORMS

- 11:4-46.1 Purpose and Scope
- 11:4-46.2 Definitions
- 11:4-46.3 Form submission requirements
- 11:4-46.4 Plan of operation requirements
- 11:4-46.5 Contract requirements
- 11:4-46.6 General requirements
- 11:4-46.7 Reserves
- 11:4-46.8 Severability

SUBCHAPTER 47. ACTUARIAL REQUIREMENTS FOR FLEXIBLE-FACTOR POLICY FORMS

- 11:4-47.1 Purpose and Scope
- 11:4-47.2 Definitions
- 11:4-47.3 General requirements
- 11:4-47.4 Pricing assumptions—actuarial certification
- 11:4-47.5 Nonforfeiture benefits—actuarial memorandum
- 11:4-47.6 Recordkeeping
- 11:4-47.7 Penalties

APPENDIX

SUBCHAPTER 48. UNFAIR DISCRIMINATION

- 11:4-48.1 Purpose and scope
- 11:4-48.2 Definitions
- 11:4-48.3 General requirements
- 11:4-48.4 Persistency bonus
- 11:4-48.5 Tiered factors
- 11:4-48.6 Conversion credits
- 11:4-48.7 Non-smoker only coverage
- 11:4-48.8 Policy benefits determined by ownership
- 11:4-48.9 Forgiveness of surrender charge
- 11:4-48.10 Discounts and reductions in premium in individual health insurance

SUBCHAPTER 49. MANDATED DIABETES BENEFITS

- 11:4-49.1 Purpose and scope
- 11:4-49.2 Definitions
- 11:4-49.3 Benefits
- 11:4-49.4 Payment of benefits under multiple coverage plans

SUBCHAPTER 50. REIMBURSEMENT OF INMATE HEALTH CARE COSTS

- 11:4-50.1 Purpose and scope
- 11:4-50.2 Definitions
- 11:4-50.3 Liability for medical care
- 11:4-50.4 Amount of inmate liability
- 11:4-50.5 Health coverage plans
- 11:4-50.6 Filing of claims for reimbursement
- 11:4-50.7 Coordination of benefits
- 11:4-50.8 Policy forms

SUBCHAPTER 1. (RESERVED)**SUBCHAPTER 2. REPLACEMENT OF LIFE INSURANCE POLICY****11:4-2.1 Purpose**

(a) The purpose of this subchapter is:

1. To regulate the activities of insurers and agents with respect to the replacement of existing life insurance;
2. To protect the interests of life insurance policyowners by establishing minimum standards of conduct to be observed in the replacement or proposed replacement of existing life insurance by:
 - i. Assuring that the policyowner receives information with which a decision can be made in his or her own best interest;
 - ii. Reducing the opportunity for misrepresentation and incomplete disclosures; and
 - iii. Establishing penalties for failure to comply with the requirements of this subchapter.

11:4-2.2 Definitions

“Cash dividend” means the current illustrated dividend which can be applied toward payment of the gross premium.

“Conservation” means any attempt by the existing insurer or its agent to continue existing life insurance in force when existing insurer has received a Comparative Information Form as required by N.J.A.C. 11:4-2.5(a)3iv from a replacing insurer. A conservation effort does not include routine administrative procedures like late payment reminders, late payment offers or reinstatement offers.

“Direct-response sales” means any sale of life insurance where the insurer does not utilize an agent in the sale or delivery of the policy.

“Existing insurer” means the insurance company whose policy is or will be changed or terminated in such a manner as described within the definition of “replacement”.

“Existing life insurance” means any life insurance in force including life insurance under a binding or conditional receipt or a life insurance policy that is within an unconditional refund period, but excluding life insurance obtained through the exercise of a dividend option.

“Generic name” means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

“Replacement” means any transaction in which new life insurance is to be purchased, and it is known or should be known to the proposing agent, or to the proposing insurer if there is no agent, that by reason of such transaction, existing life insurance has been or is to be:

1. Lapsed, forfeited, surrendered, or otherwise terminated;
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values;
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid;
4. Reissued with any reduction in cash value; or
5. Pledged as collateral or subjected to borrowing, whether in a single loan or under a schedule of borrowing over a period of time for amounts in the aggregate exceeding 25 percent of the loan value set forth in the policy.

“Replacing insurer” means the insurance company that issues a new policy which is a replacement of existing life insurance.

“Sales Proposal” means individualized, written sales aids of all kinds, excluding Comparative Information Forms and Policy Summaries, which are used by an insurer, agent or broker in comparing existing life insurance to proposed life insurance in order to recommend the replacement or conservation of existing life insurance. Sales aids of a generally descriptive nature, which are maintained in the insurer’s advertising compliance file, shall not be considered a Sales Proposal within the meaning of this definition.

11:4-2.3 Exemptions

(a) Unless otherwise specifically included, this subchapter shall not apply to:

1. Annuities;

2. Individual credit life insurance;
3. Group life insurance, group credit life insurance, and life insurance policies issued in connection with a pension, profit-sharing or other benefit plan qualifying for tax deductibility of premiums, provided, however, that as to any plan described in this subsection, full and complete disclosure of all material facts shall be given to the administrator of any plan to be replaced;
4. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account;
5. An application to the existing insurer that issued the existing life insurance and a contractual change or conversion privilege is being exercised;

6. Existing life insurance that is a non-convertible term life insurance policy which will expire in five years or less and cannot be renewed; or

7. Proposed life insurance that is to replace life insurance under a binding or conditional receipt issued by the same company.

11:4-2.4 Duties of agent

(a) Each agent shall submit to the replacing insurer with or as part of each application for life insurance:

1. A statement signed by the applicant as to whether or not such insurance will replace existing life insurance; and

11:4-44.5 Standards for individual market value adjusted annuities

(a) All individual market value adjusted annuities shall comply with the following standards:

1. The contract shall be identified and issued as a variable contract pursuant to N.J.S.A. 17B:28-1 et seq.;
2. The funds backing the contract shall be held in a separate account; and
3. The maturity value and cash value guarantees shall be obligations of the general account.

SUBCHAPTER 45. PERIODIC REPORTS**Authority**

N.J.S.A. 17:1-8.1, 17:1C-6(e), 17B:25-18, 17B:25-19, 17B:27-25, 17B:28-5, 17B:30-1 et seq.; and P.L. 1995, c.73.

Source and Effective Date

R.1996 d.150, effective March 18, 1996.
See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

11:4-45.1 Purpose and scope

(a) These rules set forth the standards and requirements for periodic reports required to be provided to policyholders or contract holders in connection with flexible-factor life insurance forms, individual variable annuity forms, and individual variable life insurance forms to be filed by the Commissioner for use and delivery in this State pursuant to N.J.S.A. 17B:25-18, 17B:27-25, 17B:28-5 and P.L. 1995, c.73, sections 15 and 16.

(b) These rules shall apply to any insurer seeking to deliver or issue for delivery in this State a flexible-factor form, individual variable annuity form or individual variable life insurance form.

11:4-45.2 Definitions

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

“Annuity” means a contract not included within the definition of life insurance as set forth in N.J.S.A. 17B:17-3, or health insurance as set forth in N.J.S.A. 17B:17-4, under which an insurer obligates itself to make periodic payments for a specified period of time, such as for a number of years, or until the happening of an event, or for life, or for a period of time determined by any combination thereof. Such a contract which includes extra benefits of the kinds set forth in N.J.S.A. 17B:17-3 or 17B:17-4 shall nevertheless be deemed to be an annuity if such extra benefits constitute a subsidiary or incidental part of the entire contract.

“Commissioner” means the Commissioner of the New Jersey Department of Insurance.

“Contract on a variable basis” means any separate account contract providing for the dollar amount of life insurance or annuity benefits or other contractual payments or values thereunder to vary so as to reflect investment results of one or more separate accounts in which amounts with respect to any such contracts shall have been placed.

“Department” means the New Jersey Department of Insurance.

“Flexible-factor form” means any life insurance policy, rider or endorsement, whether participating or non-participating, where the insurer reserves the right to modify (upward or downward) premiums, premium factors (interest, mortality, expenses) or benefits (death benefits, cash or loan values) on the basis of future anticipated or emerging experience.

“Insurer” means any person or persons, corporation, partnership, or company authorized or admitted to transact the business of life insurance or annuities in this State pursuant to Title 17B of the New Jersey Statutes.

“Life insurance” means a policy or contract whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the cessation of human life. Life insurance includes also the granting of endowment benefits and optional modes of settlement of proceeds of life insurance as well as provisions for additional benefits in event of death by accident or accidental means or in event of dismemberment or loss of sight, or safeguarding such insurance against lapse or giving a special surrender value or special benefit or an annuity in the event that the insured shall become totally and permanently disabled, whether such provisions are incorporated in a policy or contract of life insurance or in a policy or contract supplemental thereto. Life insurance does not include workmen’s compensation coverages.

“Variable annuities” or “variable life insurance” means annuity or life insurance, respectively, issued under a contract on a variable basis.

11:4-45.3 General requirements

(a) No form to which this subchapter applies may be delivered or issued for delivery in this State unless submitted to the Commissioner for review and filed by the Commissioner pursuant to all applicable law, including, but not limited to, N.J.A.C. 11:4-40.

(b) For any form to which these rules apply, the insurer shall provide the policyholder with a report or notice, as set forth in this subchapter, which provides the information and complies with the standards set forth in this subchapter.

(c) Any form submission to which these rules apply shall be accompanied by a specimen copy of the form of periodic report or form of notice to policyholders, as applicable, that the insurer shall utilize as required pursuant to this subchapter. The form of periodic report or form of notice may be manually generated.

(d) The specimen report or notice submitted pursuant to (c) above shall reflect the specimen issue of the policy under review. The specimen report or notice shall have valid entries which may be reconciled by the Department in its review, and shall display all transactions and charges allowed under the policies. The terms utilized in the report or notice shall correspond to the terms used in the policy to describe the same values, charges or transactions.

(e) The insurer shall not alter the types of information provided in the report or notice except upon 60 days' prior written notification to the Department, and provided that such changes are not disapproved by the Department within that 60 day period.

11:4-45.4 Flexible factor forms; reporting requirements

(a) For any flexible factor form where cash values and/or death benefits are subject to variation on the basis of interest, mortality, or expense factors that may be adjusted by the insurer, or on the basis of premium amounts which the policyholder may unilaterally change or choose not to pay, the insurer shall provide each policyholder with a periodic report to notify each policyholder of his or her values and benefits. The report shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show values applicable at both the beginning and end of the period covered by the report;
2. The report shall show the policy status as of a date no more than two months prior to the date of the mailing of the report and shall show all increments and decrements to values and benefits since the date as of which the last previous report provided value and benefit information;
3. Individual premiums received during the period covered by the report shall be identified as to amount, date of receipt, and the date on which the insurer first credited interest thereon, unless this information was previously provided in writing to the policyholder at the time each consideration was received;
4. Interest increments shall not be aggregated over different time periods but rather shall be segregated in sufficient detail to permit verification;
5. The report shall record all interest rates which applied to loaned and unloaned amounts during the reporting period;

i. In the case of policies with "buckets" or "generations" of interest, the Commission shall waive the requirement set forth in (a)5 above, upon request of the insurer, if the insurer:

(1) Agrees and states on the report that it will provide information regarding interest rates and the methods utilized to calculate interest credits to loaned and unloaned values to the policyholder upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record all interest rates which applied to loaned and unloaned amounts during the reporting period.

ii. Notwithstanding any waiver granted pursuant to (a)5i above, the report shall indicate the interest rate(s) which applied to new premiums during the reporting period;

6. The report shall display all transactions and charges allowed under the policies, which shall be recorded by date. However, the Commissioner shall waive this requirement with respect to the recording of loan activity, upon request of the insurer, if the insurer:

i. Agrees and states on the report that it will provide this information to the policyholder upon request and free of charge;

ii. With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

iii. The insurer demonstrates to the Commissioner that the notice shall display all transactional charges allowed under the policies recorded by date; and

7. If the value of the policy is such that it would not maintain insurance in-force until the anticipated effective date of the next periodic report, the report shall include a caution that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) For all flexible-factor forms, the insurer shall notify policyholders of changes in premiums or rating factors. The insurer shall indicate in the cover letter to the submission whether the notification required pursuant to this section shall be by periodic report, amendment to the policy form or letter.

(c) For policies to which (a) above applies, the periodic report set forth in that subsection may be utilized to satisfy the notification requirement set forth in (b) above. If so, the notification to the policyholder shall include any changes that have occurred since the effective date of the previous report together with any changes that have been finally adopted by the insurer and that will be applicable to the next subsequent reporting period.

(d) For forms which contain non-guaranteed premiums or rating factors, the notification of changes to the premiums or factors shall be in the form of a policy form amendment which shall modify all current and future non-guaranteed premium or rating factors that have changed and that were included in the original policy or in subsequent amendments. Any policy form amendments shall be submitted for review and filing by the Commissioner in accordance with applicable law.

11:4-45.5 Individual variable annuity forms; reporting requirements

(a) Any periodic report for use with an individual variable annuity shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show the values by fund, sub-account and division (including, but not limited to, dollar and unit values) applicable at both the beginning and end of the period covered by the report;

2. The report shall list the number of units and dollar value of a unit not more than two months prior to the date of the mailing of the report;

3. For the period prior to annuitization, the report shall list the number of units and the unit value by fund, sub-account or division. The units and unit value shall not be listed in the aggregate;

4. Except as provided in (a)5 below; for the period prior to annuitization, the report shall record the following transactions by date:

- i. Premium receipt;
- ii. Loans, incurred and repaid;
- iii. Partial surrenders or withdrawals; and
- iv. Transfers;

5. Alternatively to (a)4 above, for any transactions for which transaction and confirmation notices are sent, the report may show an aggregate amount for each such type of transaction, except that transfers need not be shown;

6. For the period prior to annuitization, any periodic report for use with a form which provides fixed account options shall list all interest rates which applied during the period covered by the report;

i. In the case of policies with "buckets" or "generations" of interest, the Commissioner shall waive the requirement set forth in (a)6 above, upon request of the insurer, if the insurer:

(1) Agrees and states on the report that it will provide interest rates and crediting methodology to the owner upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the owner to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record the transactions set forth in (a)4 above by date for loan activity.

ii. Notwithstanding any waiver granted pursuant to (a)6i above, the report shall record the interest rates applied to monies newly allocated to a fixed account option during the reporting period, unless such interest rates are provided by the insurer in a transaction or confirmation notice at the time of allocation; and

7. The report sent after annuitization for variable payments shall provide a reconciliation of annuity payments. The annuity unit values shall be listed by fund, sub-account or division. The units and unit values shall not be listed in the aggregate. For annuitization to fixed payments, no report is required.

11:4-45.6 Individual variable life insurance; periodic report requirements

(a) Any periodic report for use with an individual variable life form shall satisfy, at a minimum, the following requirements:

1. The report shall be provided at least annually, and shall show values by fund, sub-account and division (including, but not limited to, dollar and unit values, if the product has unit values) applicable at both the beginning and end of the period covered by the report;

2. The report shall show the policy status as of a date no more than two months prior to the date of the mailing of the report and shall show all increments and decrements to values and benefits since the date as of which the last previous report provided value and benefit information;

3. The report shall state that, in accordance with the investment experience of the separate account, the cash values and variable death benefit may increase or decrease;

4. If the report shows projected values, it shall describe the assumptions (premiums, charges, and net return) used to calculate the projections; and

5. If, as of the reporting date, any projected value shown in the report is less than zero, the report shall include a caution that the policy may be in danger of terminating without value in the next 12 months unless additional premium is paid.

(b) Any periodic report for use with an individual variable life form, which is a flexible factor form where cash values and/or death benefits are subject to variation on the basis of interest, mortality, or expense factors that may be adjusted by the insurer, or on the basis of premium amounts which the policyholder may unilaterally change or choose

not to pay, shall satisfy, at a minimum, the following requirements:

1. The report shall include a monthly display of positive and negative investment performance for each sub-account, fund or division of the separate account to which money was allocated during the reporting period;

2. Except as provided in (b)3 below, the report shall record the following transactions by date:

- i. Premium receipt;
- ii. Loans, incurred and repaid;
- iii. Partial surrenders or withdrawals;
- iv. Transfers; and
- v. Monthly deductions;

3. Alternatively to (b)2 above, for any transactions for which transaction or confirmation notices are sent, the report may show an aggregate amount for each such type of transaction, except that transfers need not be shown;

i. The Commissioner shall waive the requirement set forth in (b)2 above for loan activity, upon request of the insurer, if the insurer:

(1) Agrees and states in the report that it will provide this information to the policyholder upon request and free of charges;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record transactions set forth in (b)2 above by date for loan activity;

4. The report shall display interest increments separately from other increments and decrements. Interest increments shall not be aggregated over different time periods but shall be segregated in sufficient detail to permit verification; and

5. The report shall record all interest rates which applied to loaned and unloaned amounts during the reporting period;

i. In the case of policies with "buckets" or "generations" of interest, the Commissioner shall waive the requirement set forth in (b)5 above, upon request of the insurer, if the insurer:

(1) Agrees and states in the report that it will provide the interest rates and crediting methodology to the policyholder upon request and free of charge;

(2) With the form submission, provides a specimen copy of the form of notice to the policyholder to be utilized in accordance with N.J.A.C. 11:4-45.3; and

(3) The insurer demonstrates to the Commissioner that the notice shall record all interest rates which applied to loaned and unloaned amounts during the reporting period.

ii. Notwithstanding any waiver granted pursuant to (b)5i above, the report shall record the interest rates applied to monies newly allocated to a fixed account option during the reporting period, unless such interest rates are provided by the insurer in a transaction or confirmation notice at the time of allocation.

(c) In addition to the requirements set forth in (a) above, the periodic report and submission shall satisfy the requirement set forth in N.J.A.C. 11:4-45.4(b), (c) and (d).

11:4-45.7 Penalties

Failure to comply with this subchapter shall result in the disapproval of any flexible-factor form, individual variable annuity form, or individual variable life insurance form, as applicable, for delivery in this State, as well as the imposition of any other penalties as may be authorized by law.

SUBCHAPTER 46. SYNTHETIC GUARANTEED INVESTMENT CONTRACT FORMS

Authority

N.J.S.A. 17:1-8.1, 17:1-15(e), 17B:28-7, 17B:28-14 and P.L. 1995, c.73.

Source and Effective Date

R.1997 d.332, effective August 4, 1997.
See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

11:4-46.1 Purpose and scope

(a) The purpose of this subchapter is to implement P.L. 1995, c.73 (the Life and Health Insurance and Health Maintenance Organization Form Approval Reform Act) by setting forth the terms and conditions under which life insurance companies may issue synthetic guaranteed investment contracts, the essential operational features of the segregated portfolio of assets required to issue such contracts and the reserve requirements for such contracts.

(b) This subchapter shall apply to all synthetic guaranteed investment contract forms delivered or issued for delivery in the State.

11:4-46.2 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 Banking and Insurance.

“Contract value record” means an accounting record established pursuant to the contract in relation to the portfolio of assets which is credited with a fixed rate of return over regular periods. The contract value record is used to measure the extent of the insurer’s obligations to the contractholder.

“Crediting rate” means either:

1. A specified rate; or
2. A rate determined using a mathematical formula that calculates the fixed rate of return credited to the contract value record during any rate period, based upon:
 - i. The yield on the assets held in the segregated portfolio or an alternative benchmark portfolio; and
 - ii. The difference between the contract value record and the market value record amortized over a period of time related to the average duration of the assets held in the segregated portfolio, or an alternative benchmark against which the assets are managed.

“Custodian” means a bank, trust company or other duly licensed fiduciary services provider.

“Department” means the New Jersey Department of Banking and Insurance.

“Insurer” means a life insurance or annuity company operating pursuant to N.J.S.A. 17B:1-1 et seq. and additionally qualified pursuant to N.J.S.A. 17B:28-2 to issue separate account contracts.

“Investment guidelines” means the set of written criteria established by the contractholder setting forth the portfolio characteristics and constraints within which the investment manager may invest and reinvest the assets within the segregated portfolio.

“Investment manager” means the entity appointed to manage the segregated portfolio in accordance with the investment guidelines. The investment manager shall be:

1. An entity, including, but not limited to, the insurer offering the synthetic guaranteed investment contract, that is registered as an investment adviser under the Investment Advisers Act of 1940 (15 U.S.C. §§ 80b-1 et seq.) or any similar statute that may be enacted in substitution therefor; or
2. An entity, including, but not limited to, any bank, that lawfully may perform the functions of an investment adviser as defined under the Investment Advisers Act of 1940 or any similar statute that may be enacted in substitution therefor, but that is exempt from registration under such statute.

“Market value record” means an accounting record established by the contract in relation to the market value of the portfolio of assets and expressed as the sum of:

1. The aggregate of the prices at which the publicly traded assets held in the segregated portfolio are traded as of any valuation date, or in the case of any asset for which no such price is available (including private placement securities), a price that appropriately reflects its fair market value; plus

2. Any related cash or cash equivalents held in the segregated portfolio.

“Rate period” means the period of time during which the fixed rate of return credited to the contract value record is applicable between crediting rate formula adjustments.

“Separate account contract” is a contract as defined at N.J.S.A. 17B:28-1.

“Segregated portfolio” means a portfolio of assets to which the contract pertains that is held in a custody or trust account by a custodian and identified on the records of such custodian as special custody assets held for the exclusive benefit of the entities on whose behalf the contractholder holds the contract, and any related cash or cash equivalents received by the custodian for the account of the contractholder and held in a deposit account, cash management account or fund for the exclusive benefit of the entities on whose behalf the contractholder holds the contract.

“Synthetic guaranteed investment contract” or “contract” means a group annuity contract or other agreement that establishes the insurer’s payment obligations by reference to a portfolio of assets neither owned by nor in the possession of the insurer.

11:4-46.3 Form submission requirements

(a) In addition to complying with the requirements set forth in these rules, all synthetic guaranteed investment contract form submissions shall comply with all applicable requirements of N.J.A.C. 11:4-40.

(b) All synthetic guaranteed investment contract form submissions shall comply with the following requirements:

1. The submission shall include a plan of operation that meets the requirements set forth in N.J.A.C. 11:4-46.4. The plan of operation shall be annotated to correspond to the applicable requirements of N.J.A.C. 11:4-46.4, and shall be a separate document;

2. The submission shall include a contract form that meets the requirements set forth in N.J.A.C. 11:4-46.5. The contract shall be annotated to correspond to the applicable requirements of N.J.A.C. 11:4-46.5;

3. The submission shall include a statement identifying any requirements of N.J.A.C. 11:4-46.4 or 46.5 that the insurer considers inapplicable to its particular submission, together with a complete explanation of such inapplicability.

4. The extensive use of variable text bracketing in contract forms that permits variable text is prohibited. Such bracketing shall be minimal, and shall relate only to the names and identification of the parties to the contract or to identified parameters or scenarios as specified in any statement on variable text accompanying the contract form. Determination of the excessive use of such bracketing shall be within the sole discretion of the Department.

i. The use of variable bracketing in contract forms that permits either the omission of text or the inclusion of alternate text shall be permitted if the submission includes sufficient specimen examples showing all versions of variable text as is necessary for the Department to complete its review of the form;

5. Any revision to the plan of operation shall be submitted to the Department pursuant to this subsection at least 60 days prior to implementation. The insurer may utilize the new plan of operation provided the Department has not disapproved within the 60-day period pursuant to (b)5ii below the continued use of the previously-approved form.

i. The submission shall include a copy of the prior plan of operation with the revisions incorporated therein and annotated pursuant to (b)1 above. The revised portions of the plan of operation shall be highlighted or otherwise identified as new. The submission shall also include a certification that the remaining portions of the plan of operation are unaffected by the revision.

ii. Any revision to the contract form necessary to conform to the revised plan of operation shall be submitted to the Department for approval pursuant to this subsection. The Department reserves the right to prohibit the use of a previously-approved contract form with any revised plan of operation deemed incompatible therewith;

6. Any of the plan of operation requirements set forth N.J.A.C. 11:4-46.4 shall be waived upon request of the insurer if the state of domicile of the insurer has adopted rules that are substantially similar to these rules and has approved such plan of operation. Evidence of such approval shall be included in the submission; and

7. Any submission that fails to meet the requirements set forth in this section shall be considered incomplete, and shall be returned to the insurer for nonaction pursuant to N.J.A.C. 11:4-40.5(c).

11:4-46.4 Plan of operation requirements

(a) An acceptable plan of operation submitted in support of the Department's review of the contract shall include at least the following:

1. A description of all contingencies and circumstances under the contract that would require the insurer to make payments or perform any other obligation to the contract-holder in support of the contract value record;

2. A discussion of the consideration (risk premium and/or fee) indicating expected allocations (expressed in either specific amounts or ranges) to risk, administration and profit, and a demonstration that the consideration is appropriate in view of the risks to the insurer with respect to the contract.

i. A demonstration of how the crediting rate shall be affected by changes in interest rates and withdrawal experience. The demonstration shall include at least three hypothetical interest rate scenarios (level, increasing and decreasing), and for each scenario at least three withdrawal scenarios (zero, moderate and high) shall be modeled. Additional scenarios may be required if the Department determines it to be necessary to fully understand the risks of the contract or agreement. The demonstration period shall be for the lesser of 15 years or the maximum potential life of the contract;

3. A description of how the market value shall be calculated, including a summary description of the procedures to be followed by the insurer in verifying, through periodic spot audits or otherwise, any market value reporting performed by the contractholder or the custodian that the insurer may use as the basis for calculating the market value record. In performing the market value calculation, the method of valuation selected shall conform to the requirements of N.J.S.A. 17B:28-10;

4. A description of how the contract value record shall be determined and, where applicable, adjusted by experience rating;

5. A description of any crediting rate formula, the extent to which it shall operate to take into account differences between the market value and contract value records, and whether such rate shall be periodically adjusted to reflect experience rating. If there is no crediting rate formula, a description of the method by which the crediting rate shall be determined;

6. A statement describing in detail how the guaranteed contract liabilities are to be valued in accordance with N.J.A.C. 11:4-46.7;

7. A discussion of the investment guidelines that are acceptable to the insurer, together with a description of the procedures that will be followed by the insurer in evaluating the appropriateness of the investment guidelines, including the manner in which the insurer shall monitor the segregated portfolio and verify that it is being managed in accordance with the investment guidelines;

8. A description of any requirement for plans purchasing synthetic guaranteed investment contracts to establish a buffer fund or an allocation procedure that limits the allocable share of benefit payments made from the segregated portfolio;

2. All expenses incurred for diabetes self-management education, including information on proper diet. "Diabetes self-management education" as used in this paragraph means education to ensure that a person with diabetes is educated as to the proper self-management and treatment of their diabetic condition, including information on proper diet.

i. All self-management and diet education shall be provided by a dietician registered by a nationally recognized professional association of dietitians, a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators, or a registered pharmacist in the State qualified with regard to management education for diabetes by any institution recognized by the Board of Pharmacy of the State of New Jersey.

ii. Benefits for self-management education related to diet shall be limited to visits medically necessary upon the diagnosis of diabetes, upon diagnosis by a State licensed physician or nurse practitioner/clinical nurse specialist of a significant change in the subscriber's or other covered person's symptoms or conditions which necessitate changes in that person's self-management, and upon determination of a State licensed physician or nurse practitioner/clinical nurse specialist that re-education or refresher education is necessary.

(b) The benefits required to be provided pursuant to this subchapter shall be provided to the same extent as benefits are provided for services and supplies for any other sickness under the policy or contract. There shall be no separate deductible, coinsurance or maximum limit applicable to the services and supplies set forth in (a) above.

11:4-49.4 Payment of benefits under multiple coverage plans

All group health insurance policies or contracts providing hospital or medical expense benefits, except for policies or contracts providing prescription drug benefits, may provide that the benefits required to be provided pursuant to this subchapter are excluded if the benefits are included under another group health insurance policy or contract issued to the same policyholder or contractholder.

SUBCHAPTER 50. REIMBURSEMENT OF INMATE HEALTH CARE COSTS

Authority

N.J.S.A. 17:1-8.1, 17:1-15e, and 30:7E-3f.

Source and Effective Date

R.1997 d.513, effective December 1, 1997.
See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

11:4-50.1 Purpose and scope

(a) In conformance with N.J.S.A. 30:7E-1 et seq., the purpose of this subchapter is to establish rules for the reimbursement of costs incurred in the provision of medical care, hospitalization, surgery, dental care and vision care to inmates that are covered by a health coverage plan and are incarcerated or detained in a State or county institution.

(b) These rules shall not apply to those self-funded health care plans which are subject to the Employee Retirement Income Security Act of 1974 (ERISA).

(c) Pursuant to P.L. 1997, c.216, section 3, the Administrative Office of the Courts, in accordance with these rules, shall be permitted to file claims for reimbursement, subject to the terms of coverage, for the psychological evaluation of convicted persons.

11:4-50.2 Definitions

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

"Confinement" means incarceration, detention or commitment to any institution.

"Correctional medical services subcontractor" and "correctional medical services health care provider" are those private associations, agencies or companies hired or contracted by the State or counties to provide medical care, services, or products to inmates.

"Covered person" means any person who is covered by a health coverage plan but not as an enrollee.

"Enrollee" means a person who receives or subscribes to a policy, contract, certificate, evidence of coverage or other proof of coverage from the health coverage plan that covers that person for health benefits and expenses.

"Health coverage plan" means any hospital or medical expense insurance policy; health, hospital or medical service corporation contract or certificate; or health maintenance organization ("HMO") subscriber contract or evidence of coverage; dental plan organization, contract or certificate ("DPO"); dental service corporation, contract or certificate ("DSC"); or vision plan.

"Inmate" means any person sentenced to confinement or held in pretrial detention in an institution.

"Institution" refers to any State correctional facility, State contracted half-way house, county jail, county correctional or detention facility.

11:4-50.3 Liability for medical care

Inmates are liable for the cost of any medical care, surgery, medical service, nursing care, prescription drugs,

nonprescription drugs, durable medical equipment, hospitalization, therapy treatment, dental care, vision care provided to them while in confinement.

11:4-50.4 Amount of inmate liability

Pursuant to N.J.S.A. 30:7E-2, the amount of inmate liability for medical care shall be the usual, customary and reasonable charges incurred for the inmate's medical care as determined by the State and county treasurers in accordance with the guidelines promulgated by the Commissioner of Corrections or the County Adjuster.

11:4-50.5 Health coverage plans

(a) In accordance with N.J.S.A. 30:7E-3, State and County Treasurers shall file a claim for reimbursement of the value of the usual, customary and reasonable charges incurred for an inmate's medical care upon any health coverage plan providing benefits to an inmate as an enrollee or as a covered person.

(b) Subject to the terms of coverage of the policy or plan, health coverage plans shall be required to reimburse the State or county for costs expended in providing medical care to any inmate covered under the plan.

(c) Notwithstanding the provisions of N.J.A.C. 8:38-1.2 (definition of "emergency"), it shall be presumed that inmates are in need of emergency medical care and are not located in a place where it can be rendered by any network health care provider. The institutional medical health care provider is deemed to be the inmate's only available source of medical care.

(d) Where practicable, the institutional health care provider shall confer with the health coverage plan to preserve the right of said plans to negotiate fees for testing, specialists and hospitalization.

11:4-50.6 Filing of claims for reimbursement

(a) Where the inmate is an enrollee, he or she shall provide a signed and completed assignment of benefits form in favor of the treasurer of the State or county institution, a claims form and a medical release. These forms shall be obtained from the inmate's plan. The assignment of benefit form shall designate the State or County Treasurer as the assignee for the reimbursement of benefits. Such forms shall be used by the institution to process claims for reimbursement.

(b) Where the inmate is a covered person under a policy or plan of health insurance, the enrollee shall complete the assignment of benefits form designating the State or county treasurer of the institution as the recipient for the reimbursement of benefits. Thereafter, the inmate shall execute all claims and medical release forms.

(c) The forms and claims filing procedures established by the health care plan shall, in so far as practicable, be followed by the institution to facilitate the reimbursement of benefits. All health care plans shall cooperate in the expeditious processing of claims for reimbursement received from institutions rendering medical services, care and products to inmates.

(d) All health care plans shall be obligated, notwithstanding their approved policy terms and procedures, to accept any assignment of benefits executed by or on behalf of an inmate for medical care and services provided to the inmate while institutionalized.

(e) All reimbursement payments for medical care provided to an inmate shall be made payable to the State or county treasurer of the institution designated on the assignment of benefits form.

11:4-50.7 Coordination of benefits

(a) The determination of primary coverage responsibility shall be governed by N.J.A.C. 11:4-28 to determine the priority of reimbursement in the event of multiple coverages of an inmate.

(b) For the purpose of the coordination of benefits, the medical services provided by the institution, the correctional medical service subcontractor and the correctional medical service health care provider shall not be considered a "plan" as defined in N.J.A.C. 11:4-28.

11:4-50.8 Policy forms

Health coverage plans shall not contain any provision which would limit or restrict the ability of the State or county treasurers to seek reimbursement for the cost of medical services provided to inmates under N.J.S.A. 30:7E-1 et seq.