

**CHAPTER 4**  
**ACTUARIAL SERVICES**

**Authority**

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

**Source and Effective Date**

R.2001 d.7, effective November 30, 2000.  
See: 32 N.J.R. 3546(a), 33 N.J.R. 101(a).

**Executive Order No. 66(1978) Expiration Date**

Chapter 4, Actuarial Services, expires on November 30, 2005.

**Chapter Historical Note**

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

Subchapter 2, Replacement of Life Insurance Policy, was adopted as R.1972 d.21, effective April 1, 1972.

Subchapter 7, Procedure for the Regulation of Consent to Higher Rate Filings, was adopted as R.1973 d.82, effective April 15, 1973. See: 4 N.J.R. 220(a), 5 N.J.R. 113(b).

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

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

Subchapter 13, Group Student Health Insurance, was adopted as 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 R.1977 d.476, effective December 15, 1977. See: 9 N.J.R. 479(f), 10 N.J.R. 16(d).

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

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

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).

Pursuant to Executive Order No. 66(1978), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings, were readopted as R.1980 d.343, effective August 5, 1980. See: 12 N.J.R. 420(c), 12 N.J.R. 538(b).

Subchapter 21, Limited Death Benefits Forms, was adopted as R.1980 d.265, effective June 18, 1980. See: 12 N.J.R. 279(b), 12 N.J.R. 423(c).

Subchapter 2, Replacement of Life Insurance Policy, was repealed and Subchapter 2, Replacement of Life Insurance Policy, was adopted as new rules by R.1982 d.16, effective February 1, 1982, operative June 1, 1982.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

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

Subchapter 22, Individual Life Insurance: Use of Gender Blended Mortality Tables, was adopted as 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).

Subchapter 23, Medicare Supplement Policies and Contracts, was adopted as 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, Blindness; Partial Blindness or Other Physical or Mental Impairments; Unfair Discrimination, 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), Subchapter 16, Minimum Standards for Individual Health Insurance, Subchapter 17, Health Insurance Solicitation, and Subchapter 18, Individual Health Insurance Rate Filings 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 Nonsmoker Mortality Tables, was adopted as 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 R.1985 d.616, effective December 2, 1985. See: 17 N.J.R. 2349(a), 17 N.J.R. 290(a).

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

Subchapter 19, Optional Coverage for Pregnancy and Childbirth Benefits, was adopted as 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).

Subchapter 29, Homeowners Comparison Survey, was adopted as 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 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 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 R.1989 d.571, effective November 6, 1989. See: 21 N.J.R. 1964(a), 21 N.J.R. 3465(a).

Subchapter 25, Medicare Supplement Interim Standards, was adopted as R.1990 d.214, effective April 16, 1990. See: 22 N.J.R. 320(a), 22 N.J.R. 1266(b).

Pursuant to Executive Order No. 66(1978), Chapter 4 was readopted as R.1991 d.3, effective November 30, 1990, Subchapter 1, Contracts on a Variable Basis, was repealed by R.1991 d.3, 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 R.1991 d.122, effective March 4, 1991. See: 22 N.J.R. 1226(b), 23 N.J.R. 698(a).

Petition for Rulemaking. See: 23 N.J.R. 2546(c), 23 N.J.R. 3827(a).

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

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

Subchapter 9, Personal Lines Insurance: Prospective Loss Costs Filing Procedures, was adopted as 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 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 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).

Administrative correction. See: 27 N.J.R. 4728(a).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.1996 d.4, effective November 30, 1995, and 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 by R.1996 d.4, effective January 2, 1996. See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

Subchapter 47, Actuarial Requirements for Flexible-Factor Policy Forms, was adopted as new rules by R.1996 d.83, effective February 5, 1996. See: 27 N.J.R. 3750(a), 28 N.J.R. 1215(a).

Subchapter 44, Standards for Contracts on a Variable Basis, was adopted as new rules by R.1996 d.149, effective March 18, 1996. See: 27 N.J.R. 3743(a), 28 N.J.R. 1546(a).

Subchapter 45, Periodic Reports, was adopted as new rules by R.1996 d.150, effective March 18, 1996. See: 27 N.J.R. 3744(a), 28 N.J.R. 1548(a).

Subchapter 43, Individual Annuity Contract Form Standards, was adopted as new rules by R.1996 d.181, effective April 1, 1996. See: 27 N.J.R. 3740(a), 28 N.J.R. 1885(a).

Subchapter 48, Unfair Discrimination, was adopted as new rules by R.1996 d.182, effective April 1, 1996. See: 27 N.J.R. 3756(a), 28 N.J.R. 1887(a).

Subchapter 23A, Medicare Supplement—Under 50 Coverage, and Subchapter 23B, Medicare Supplement—Age 50 through 64 Coverage were adopted as new rules by R.1996 d.195, effective April 15, 1996. See: 27 N.J.R. 3719(a), 28 N.J.R. 1987(a).

Subchapter 42, Group Life, Group Health and Blanket Insurance: General Standards for Contract Provisions, was adopted as new rules by R.1996 d.196, effective April 15, 1996. See: 27 N.J.R. 3735(a), 28 N.J.R. 2003(a).

Subchapter 41, Standards for Individual Life Insurance Policy Forms, was adopted as new rules by R.1996 d.197, effective April 15, 1996. See: 27 N.J.R. 3727(a), 28 N.J.R. 1992(a).

Subchapter 25, Funeral Insurance Policies, was adopted as new rules by R.1996 d.328, effective July 15, 1996. See: 28 N.J.R. 1656(a), 28 N.J.R. 3671(a).

Subchapter 49, Mandated Diabetes Benefits, was adopted as new rules by R.1997 d.86, effective February 18, 1997. See: 28 N.J.R. 4340(a), 29 N.J.R. 562(a).

Subchapter 46, Synthetic Guaranteed Investment Contract Forms, was adopted as new rules by R.1997 d.332, effective August 4, 1997. See: 29 N.J.R. 1472(a), 29 N.J.R. 3452(b).

Subchapter 50, Reimbursement of Inmate Health Care Costs, was adopted as new rules by R.1997 d.513, effective December 1, 1997. See: 29 N.J.R. 2232(a), 29 N.J.R. 5066(a).

Subchapter 52, Life Insurance Illustrations, was adopted as new rules by R.1998 d.338, effective July 6, 1998. See: 30 N.J.R. 47(a), 30 N.J.R. 2495(a).

Subchapter 32, Valuation of Life Insurance Policies, was adopted as new rules by R.1999 d.442, effective December 20, 1999 (operative January 1, 2000, except as provided in N.J.A.C. 11:4-32.6). See: 31 N.J.R. 2845(a), 31 N.J.R. 4268(c).

Pursuant to Executive Order No. 66(1978), Chapter 4, Actuarial Services, was readopted as R.2001 d.7, effective November 30, 2000. See: Source and Effective Date.

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**SUBCHAPTER 1. NEW JERSEY INSOLVENT  
HEALTH MAINTENANCE ORGANIZATION  
ASSISTANCE ASSOCIATION**

**Source and Effective Date**

R.2001 d.122, effective April 2, 2001.  
See: 32 N.J.R. 3907(a), 33 N.J.R. 1109(a).

**Authority**

N.J.S.A. 17:1-8.1; 17:1-15e; and 17B:32B-1 et seq.

10. "Partial disability" shall be defined in relation to the individual's inability to perform one or more but not all of the "major", "important", or "essential" duties of employment or occupation or may be related to a "percentage" of time worked or to a "specified number of hours" or to "compensation". Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

11. "Residual disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major", "important", or "essential" duties of employment or occupation, or to the inability to perform all usual business duties for as long as is usually required. A policy which provides for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability", the insurer may use "proportionate disability" or other term of similar import which in the opinion of the Commissioner adequately and fairly describes the benefit.

12. "Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof" or words of similar import.

13. "Medicare eligible person" shall include any person who is eligible by reason of age for Medicare as defined in paragraph 12 above.

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

15. "Guaranteed renewable insurance" means all individual insurance which grants an insured the right to continue the policy in force by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44 for at least five years from the date of issue of the policy, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may make changes in premium rates by classes.

16. "Noncancellable insurance" or "noncancellable and guaranteed renewable insurance" means all individual insurance which gives the insured the right to continue the insurance in force by the timely payment of premiums set forth in the policy until at least age 50, or in the case

of a policy issued after age 44 for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while it is in force.

17. "Nonrenewable for stated reasons only insurance" means all individual insurance which limits the insurer's right of nonrenewal to reasons stated in the policy. The following are acceptable reasons:

- i. Fraud in applying for the policy;
- ii. Fraud in the submission of claims;
- iii. Duplication of benefits or overinsurance in accordance with insurer's standards;
- iv. Attainment of a specified age;
- v. Discontinuance of all policies issued on the same form in this State;
- vi. In policies issued to employees of an employer or to members of an association:
  - (1) Termination of employment or membership;
  - (2) Discontinuance of all policies issued on the same form to employees of the employer or to members of the association.
- vii. Change of the insured's occupation to an occupation classified as more hazardous than the original occupation;
- viii. Other reasons for nonrenewal which are appropriate to the coverage may be used if they are approved by the commissioner.

Emergency Amendment, R.1990 d.625, effective November 26, 1990 (expires January 25, 1991).

See: 22 N.J.R. 3777(a).

Amended to effectuate the purpose and intent of Section 6 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8 ("FAIR Act"), which becomes operative January 1, 1991.

Adopted Concurrent Proposal, R.1991 d.90, effective January 25, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Provisions of emergency amendment R.1990 d.625 readopted without change.

#### 11:4-16.5 Prohibited policy provisions

(a) No policy shall provide coverage for specified disease(s) or for procedures or treatments which are limited to specified diseases.

(b) No policy except a short term, nonrenewable trip policy shall provide coverage solely for specifically identified kind(s) of accident(s); however a policy may provide increased benefits for specifically identified accident(s) for any accident only coverage specified in section 6(g) of this subchapter.

(c) No policy shall provide for the payment of a single premium for the entire term of the policy, except for nonrenewable policies issued for a term of one year or less.

(d) No policy shall provide benefits which duplicate the specific benefits provided by Part A or Part B of Medicare (benefits for which the insured is eligible to enroll).

(e) A limited benefit health policy which provides only social insurance benefits (insurance which pays benefits when government mandated program benefits are not payable) may be issued if it meets the conditions stated at N.J.A.C. 11:4-16.6(e)3.

(f) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six months.

1. The initial renewal subsequent to the issuance of any policy or rider as a dividend shall clearly disclose that the policyholder is renewing the coverage that was provided as a dividend for the previous term and that such renewal is optional with the policyholder.

(g) A cash value or premium refund benefit may only be included in Disability Income Protection Coverage and only if it meets the conditions set forth in N.J.A.C. 11:4-16.6(g)2. No other policy shall provide a return of premium upon termination or suspension of coverage, retroactive waiver of premium paid during disability or payment of dividends on participating policies.

(h) No policy shall include a provision which predicates payment of benefits on the insured being house or home confined.

(i) Except as provided in N.J.A.C. 11:4-16.4(a)2, no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary or waiting period for other than newborn children not to exceed six months for specified diseases or conditions and losses resulting therefrom for hernia, disorder of reproductive organs, varicose veins, adenoids, appendix and tonsils. However, the permissible six months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain probationary or waiting periods.

(j) Except where a condition is specifically excluded by the terms of the policy, no policy shall exclude coverage for a loss due to a preexisting condition:

1. For a period greater than 24 months following the effective date of coverage where the insurer uses an application form designed to elicit the complete health history of the insured and on the basis of that application underwrites in accordance with the insurer's established standards; or

2. For a period greater than 12 months following the effective date of coverage where the insurer elects to use a simplified application, with or without a question as to the insured's health at the time of application, or elects not to use any application.

(k) Policies providing hospital confinement indemnity benefits shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(l) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Preexisting conditions other than congenital anomalies of a covered newborn dependent child;
2. Mental or emotional disorders and drug addiction;
3. Normal pregnancy and childbirth;
4. Illness, treatment or medical condition arising out of:
  - i. War or act of war (whether declared or undeclared), participation in a riot or insurrection, service in the armed forces or units auxiliary thereto;
  - ii. Suicide (while sane or insane), attempted suicide or intentionally self-inflicted injury;
  - iii. Aviation, other than as a fare paying passenger on a regularly scheduled airline;
  - iv. With respect to short-term nonrenewable policies, interscholastic sports.
5. Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered newborn dependent child which has resulted in a functional defect;
6. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;
7. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column;
8. Treatment provided in a government hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, out-of-State automobile insurance coverage as defined at N.J.A.C. 11:3-37.2 and provided for at N.J.A.C. 11:3-37.3; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

9. Dental care or treatment;
10. Eye glasses, hearing aids and examination for the prescription or fitting thereof;
11. Rest cures, custodial care, transportation and routine physical examinations;
12. Territorial limitations.

(m) A policy issued as a "Medicare supplement policy" pursuant to N.J.A.C. 11:4-16.6(j) shall not include limitations or exclusions which are more restrictive than those of Medicare for any type of care covered under the policy.

(n) No policy shall include a provision which gives the insurer an unconditional right of nonrenewal.

(o) No policy shall include a provision which reduces, limits or excludes benefits solely on the basis of the sex or marital status of the insured.

(p) Except with respect to Medicare supplement policies as defined in N.J.A.C. 11:4-16.6(j), other provisions of this regulation shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting disease, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance either the full text of the waiver is contained on the first page or specification page of the policy or prominent notice of the waiver appears on the first page or specification page. Waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions shall not be used in Medicare supplement policies.

(q) Except as otherwise provided in N.J.A.C. 11:4-16.8(b)4, the terms "Medicare supplement", "Medigap", and words of similar import shall not be used unless the policy is issued in compliance with N.J.A.C. 11:4-16.6(j).

Emergency Amendment, R.1990 d.625, effective November 26, 1990 (expires January 25, 1991).

See: 22 N.J.R. 3777(a).

Amended to effectuate the purpose and intent of Section 6 of the Fair Automobile Insurance Reform Act of 1990, P.L. 1990, c.8 ("FAIR Act"), which becomes operative January 1, 1991.

Adopted Concurrent Proposal, R.1991 d.90, effective January 25, 1991. See: 22 N.J.R. 3777(a), 23 N.J.R. 597(a).

Provisions of emergency amendment R.1990 d.625 readopted without change.

Amended by R.1996 d.4, effective January 2, 1996.

See: 27 N.J.R. 3557(a), 28 N.J.R. 165(a).

#### 11:4-16.6 Minimum standards for benefits

(a) The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsections. No individual health insurance policy shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Commissioner finds that such

policies can be filed as a limited benefit health coverage and the outline of coverage complies with the appropriate outline in N.J.A.C. 11:4-16.8.

(b) Nothing in this section shall preclude the issuance of any policy combining two or more categories of coverage set forth in this section.

(c) General rules include the following:

1. All policies, except short-term nonrenewable policies, Medicare supplement policies and as otherwise provided in this paragraph, shall provide that the policyholder shall have the right to return the policy within 10 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to Medicare supplement policies and policies issued pursuant to direct response solicitation, the policy shall provide that the policyholder shall have the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

2. A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

3. In a family policy covering both husband and wife the age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the definition of "noncancellable" or "guaranteed renewable". However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force as to the younger spouse to the age or for the duration specified in said definition.

4. If a policy contains a status type military service exclusion or a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rata basis.

5. Policies which provide normal pregnancy and child-birth benefits shall cover pregnancy if conception occurs after the effective date of coverage or after a probationary period of not more than 30 days after the effective date of coverage.

6. In the event the insurer cancels or refuses to renew, policies providing normal pregnancy benefits shall provide for an extension of benefits as to pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force.

7. Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

8. Policies which provide surgical benefits based on a surgical schedule shall also provide that procedures not listed in the schedule and not otherwise excluded shall be covered on a basis consistent with listed procedures of comparable severity.

9. In a policy which provides a second surgical opinion benefit, the following conditions must be met:

i. The benefit includes a definition of elective surgery which is sufficiently clear to permit the average insured to distinguish between "elective" and "nonelective" surgery.

ii. Second surgical opinions will be rendered only by specialists who are clearly qualified in their field, who are independent of the physician who makes the original recommendation for surgery, and who have no financial interest in the outcome (for or against surgery) of their recommendations. "Clearly qualified" will be deemed satisfied by board certification in the field of proposed surgery or in the field of medical specialization concerned with the organ involved. "Independent" will be assumed if names of qualified second opinion specialists are provided by the insurer, although the insurer may provide other methods of designating specialists that result in an equal degree of independence. "No financial interest" will be deemed to exist if the specialist providing second opinions is prohibited from performing the recommended surgery, if his remuneration is not dependent on the nature of his recommendation, and if he has no financial involvement of any nature in a partnership, corporation, or office with the first physician recommending surgery.

iii. A second surgical opinion cannot be mandatory unless the insurer is able to provide to the insured names of qualified specialists who are within convenient access to the insured. "Mandatory" means that payment of claims for elective surgery is conditioned on having obtained a second opinion.

iv. If the policy requires the insured to pay for any part of the second surgical opinion (copayment, deductible, maximum amount), the premium for the policy cannot exceed the premium payable for a comparable policy without second surgical opinion benefits, and the insurer shall disclose to the insured that his or her out-of-pocket expenses may exceed the expenses which would result from an otherwise comparable policy without a second surgical opinion benefit. See N.J.A.C. 11:4-16.8(d), (e) and (f) for disclosure requirements.

10. Any policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

11. A policy may contain a provision relating to recurrent disabilities; provided however, that no such provision shall specify that a recurrent disability be separated by a period greater than six months. A subsequent disability due to an unrelated cause is not a recurrent disability.

12. Policies which provide disability benefits that are limited to business or professional expenses must also provide for a pro rata premium refund at the request of the insured, if such expenses cease (e.g., a professional person discontinues his office). The premium refund may be limited to one year's premium.

13. If disability is a criterion for payment of benefits under a policy, the policy must include a definition of disability.

14. Policies which provide disability benefits shall provide that a period of disability begins on the date disability commences. A period of disability shall not be based on the date of first medical treatment.

15. Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurs while the policy was in force.

16. Accidental death and dismemberment benefits shall be payable if the loss occurs within 90 days from the date of the accident. There shall be no requirement that the insured be disabled or that the policy be in force at the time of loss.

17. When accidental death and dismemberment coverage is part of the insurance coverage offered under the contract, the insured shall have the option to include all insureds under such coverage and not just the principal insured.

18. Specific injury benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

19. A policy which provides benefits for injury sustained while the insured is riding in a vehicle shall not require that the insured be within the enclosed part of the vehicle.

20. In a policy which includes an option to purchase additional insurance, the following conditions must be met:

i. The option can only be included in a policy which is noncancellable or guaranteed renewable.

2. That the company has provided its agents with information about the expense allocation method used by the company in its illustrations and disclosed as required in (c)6 above.

(g) The annual certifications shall be provided to the Commissioner each year by a date determined by the insurer. Subsequent annual certifications shall be provided by the anniversary date of the initial annual certification, or a request to change the date of certification with a full explanation of the basis of the request shall be filed by that date. The original certifications shall be mailed to the following address:

New Jersey Department of Banking and Insurance  
Life and Health Division  
Life Bureau Actuary  
PO Box 470  
Trenton, New Jersey 08625-0470

One copy of the certifications shall be mailed to the following address:

New Jersey Department of Banking and Insurance  
Division of Enforcement and Consumer Protection  
PO Box 329  
Trenton, New Jersey 08625-0329

(h) If an insurer changes the illustration actuary responsible for all or a portion of the company's policy forms, the

insurer shall notify the Commissioner of the fact within 10 days and disclose the reason for the change.

#### 11:4-52.10 Penalties

In addition to any other penalties provided by the laws of this State, an insurer or producer that violates a requirement of these rules shall be guilty of a violation of N.J.A.C. 11:2-17.

#### 11:4-52.11 Transition

(a) Until January 1, 1999, insurers may use the following language instead of the statement required by N.J.A.C. 11:4-52.5(d)1: "I have received a copy of this illustration and understand that any non-guaranteed elements illustrated are subject to change and could be either higher or lower. The agent has told me they are not guaranteed." After January 1, 1999, insurers shall comply with the requirements of N.J.A.C. 11:4-52.5(d)1.

(b) Until January 1, 1999, insurers may use the language set forth in the NAIC Life Insurance Illustrations Model Regulation at Section 9B(1), incorporated herein by reference, which includes an acknowledgement by the applicant that no illustration conforming to the policy applied for was provided and that an illustration conforming to the policy as issued will be provided no later than at the time of policy delivery. After January 1, 1999, insurers shall comply with the requirements of N.J.A.C. 11:4-52.7(c).